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Medicare

State Medicaid Manual

Part 15 - Medicaid Eligibility Determination and Information Retrieval System

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Health and Human Services
Health Care Financing Administration
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PART 15

STATE MEDICAID MANUAL

(SMM)

MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM
(MEDIRS)

READEX FICHE best copy available

FOREWORD

Part 15 of the State Medicaid Manual - the Medicaid Eligibility Determination and Information Retrieval System (MEDIRS) - is being published as a guidance document at this time. The Code of Federal Regulations (42 CFR 433.115) requires the publication of a proposed notice with comment period and a final notice in the Federal Register "whenever the Administrator modifies requirements for approval of systems under 433.112 and 433.113." This applies to the provision of 90 percent Federal financial participation (FFP) for design, development, installation or improvement and 75 percent FFP for operation of mechanized Medicaid claims processing and information retrieval systems. Pursuant to these regulations, the Health Care Financing Administration (HCFA) is preparing a proposed notice for the Medicaid Eligibility Determination and Information Retrieval System (MEDIRS).

As publication of the proposed notice is not expected until fiscal year 1984 and numerous States are currently in the process of preparing advance planning documents (APDs) for Medicaid eligibility systems, this MEDIRS material is being released to assist States in the interim. It describes HCFA's current funding of Medicaid eligibility systems, and the data elements and functions HCFA will expect automated Medicaid eligibility systems to encompass.

States with an approved Medicaid Management Information System (MMIS), or an approved APD for an MMIS may qualify for enhanced funding of Statewide Medicaid eligibility systems. State implementation of Medicaid eligibility systems to support or supplant the MMIS recipient subsystem is currently optional.

The material in Part 15 is subject to revision due to comments received in conjunction with the proposed Federal Register publication and future legislative changes. Transmittals reporting changes will be released to the holders of record. Part 15 is not currently binding and is intended only for guidance or informational purposes at this time.

Additional copies of Part 15 may be obtained through the Health Care Financing Administration regional offices. Inquiries may be addressed to:

Health Care Financing Administration
State Eligibility and Buy-In Systems Branch, DES, OMS, BPO
G-E-7 Meadows East Building
6325 Security Boulevard
Baltimore, Maryland 21207

Health Care Financing Administration

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INTRODUCTION

CHAPTER 1

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15100. GENERAL

The determination of Medicaid eligibility is a time consuming process for State agencies. It involves the accumulation of numerous paper records and requires accurate and extensive verification to uphold program integrity. The eligibility determination process can become a drain on State personnel, storage facilities and financial resources resulting in slower and/or incomplete service to recipients and inaccurate or incomplete data. This results in inadequate support for operating Medicaid Management Information Systems (MMIS). MEDIRS is intended to assist States in the design of automated eligibility determination systems to alleviate these problems. The operation of Statewide mechanized eligibility determination systems will benefit States by accomplishing:

More accuracy in computations through the automation of manual operations,

Reduction in the duplication of efforts among different programs,

Reduced verification time,

Greater consistency in the application of regulations,

Reduction in the quantity of paper records retained,

An enhanced ability to handle future program changes, and

More equitable treatment of claimants.

15105. BACKGROUND

In October 1972, P.L. 92-603 was enacted. Section 235 provided for 90 percent Federal Financial Participation (FFP) for design, development and installation and 75 percent FFP for operation of State mechanized claims processing and information retrieval systems approved by the Secretary. 42 CFR 433 subpart C contains the implementing regulations. The responsibility for administration of the regulation as it applies to development and operation of Medicaid eligibility systems was assigned to the Office of Methods and Systems, Bureau of Program Operations of the Health Care Financing Administration.

15110. SCOPE OF MANUAL

This manual contains the functional requirements, data requirements, and data element dictionary for use and inclusion in the design of a State MEDIRS. It also contains the evaluation criteria used by HCFA in the assessment of an advance planning document (APD) requesting enhanced funding.

15115. POLICIES GOVERNING FEDERAL APPROVAL OF STATE MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEMS

A. Applicable Federal Approval Requirement

The most current Public Laws, Federal regulatory guidelines, applicable functional and data requirements and DHHS legal opinions form the requirements against which State Medicaid eligibility determination system projects are evaluated for increased FFP. The Administration may, at any time, promulgate new regulatory requirements. In such cases, States will be notified of the additional requirements which must be met for the State to receive enhanced FFP.

B. Term of Approval of a State's MEDIRS

Under current statutory provisions, a MEDIRS, once approved, continues to be eligible for enhanced FFP at the 75 percent matching rate for operation as long as the initial conditions for approval are maintained. Certification requirements and performance standards are currently being developed. Any new HCFA required MEDIRS revision will be published using the Notice of Proposed Rulemaking procedure per 42 CFR 433.115. HCFA intends to release information concerning any planned MEDIRS changes to States simultaneously with the distribution of policy changes. Operational MEDIR systems will be given a reasonable amount of time to develop and install systems modifications for the new requirements.

Failure by a State to meet required conditions for enhanced FFP may result in a finding of noncompliance and be sufficient cause for reduction of enhanced FFP.

C. Periodic Review of State MEDIRS Operations

An approved State title XIX system will be reviewed periodically to determine if it meets established standards of performance and operates efficiently, effectively and economically. Performance reviews for approved MMIS's are mandated by section 1903(r)(4)(A) of the Act.

15120. GLOSSARY OF TERMS

AABD -	Aid to the Aged, Blind and Disabled.
AB -	Aid to the Blind.
Act (the) -	The Social Security Act.
Administration (the) -	The Health Care Financing Adminstration.
AFDC -	Aid to Families with Dependent Children.
Agency -	Refers to the State Medicaid agency; may refer to another entity if indicated by context.

APD -	Advance planning document.
APTD -	Aid to the Permanently and Totally Disabled.
Audit Trail -	A means for identifying the actions performed on data by tracing the data path from input to output or vice versa.
Automated -	Computerized.
Backup -	A procedure, technique or hardware intended to be used in an emergency to help substitute for lost or destroyed data or to keep a system running.
Batch Processing -	The grouping of data prior to processing.
BENDEX -	Beneficiary Data Exchange; Report of SSA beneficiary information issued to the States.
Buy In -	A program whereby a State can establish coverage and pay the Medicare Part B Medical Insurance premium for individuals entitled to Medicaid and Medicare. The conditions for the State's establishment of coverage are specified in the Buy-In Agreement between the State and HCFA.
Case Identifier -	Unique Medicaid identification number assigned by a State; local jurisdictions may also use a "case number" to identify eligible family members at the same address.
Categorically Needy -	Recipients of AFDC, SSI or State supplements who are automatically eligible for Medicaid; may also include some optional coverage groups, e.g., medical assistance only cases.
CFR -	Code of Federal Regulations.
Claimant -	Applicant for Medicaid benefits; may sometimes be used as a general word referring to both applicants and recipients.
Color of Law -	Provision of the Immigration statutes by which certain immigrants are allowed to legally reside in the United States without having received pre-admission Immigration and Naturalization Service clearance, e.g., entry before June 30, 1948, certain refugees.

Contract Life Cycle -	The period of time covered by a contract.
Cost Allocation Algorithm -	A formula used to determine what portion of certain system costs will be paid by individual Federal agencies when a system offers benefits to more than one.
Cost/Benefit Analysis -	A study to determine whether the financial benefits to be gained through implementation of a change exceed the total cost of the implementation and justify any other disruptions resulting from the change.
Data Base Management -	A general term that collectively describes those functions of the control program that provide access to data, enforce data storage conventions and regulate the use of input/output devices.
Data Element Dictionary - (DED)	A listing of data elements and their significance; the dictionary also shows the date of last change, acceptable synonyms and abbreviations, pertinent remarks, values and codes.
Data Elements -	Individual pieces of information needed to complete the record for a Medicaid claimant or recipient.
Data Exchange -	The transfer of information from one system or program to another.
Data Requirements -	Information legally needed to establish Medicaid entitlement.
Deem -	Assume to be available for the use of, e.g., income or resources deemed from spouse to spouse or parent to minor child.
Disregards -	Those types or amounts of income or resources which are not counted when determining Medicaid entitlement.
Edit -	A process by which new data fed into a system is compared with data already in the system to detect errors or discrepancies.
EDP -	Electronic data processing.
EPSDT -	Early and Periodic Screening, Diagnosis and Treatment.

Essential Person -	A person determined necessary for the care of a qualified individual under titles I, X, XIV, or XVI of the Act as in effect for December, 1973.
Evaluation Criteria -	Guidelines for determining whether the advance planning document submitted for a State computer system contains adequate and sufficient information to allow HCFA to fund the system at an enhanced (90%/75%) rate.
Fair Market Value -	The anticipated amount of money one could receive for an item if sold in the open market.
FFP -	Federal Financial Participation; the Federal Government's share of a State's expenditures under the Medicaid program.
First Full Month -	The first entire month (covering the first through the last day of the month) to begin after an event occurs.
Functional Requirements -	Those processes which must be exercised to determine Medicaid entitlement.
Funding (Enhanced or Incentive) -	90 percent HCFA funding for the design, development, installation and improvement and 75 percent HCFA funding for the operation of mechanized claims processing and information retrieval systems.
Funding Sources -	Various Federal agencies providing funding for welfare activities, e.g., HCFA, SSA, USDA.
Hard Copy -	A paper record or a paper input or output document.
Hardware -	Computer equipment.
HCFA -	Health Care Financing Administration.
HHS (or DHHS) -	Department of Health and Human Services.
ICF -	Intermediate Care Facility.
In-House -	Within the State Medicaid agency; not involving the hiring of an outside contractor.

Input -	Data being received, or to be received into a device or into a computer program.
Intangible Benefits -	Associated benefits of system implementation not physically measurable e.g., improved employee morale, more efficient office organization.
Integrated (Integrable) -	A system or data base encompassing the data needed by more than one welfare related program; e.g., a system which contains the data needed to determine eligibility and maintain entitlement records for the Medicaid, AFDC, Food Stamps, and Child Support Enforcement programs.
Interface -	A shared boundary; the interaction of two or more systems to exchange information of common interest.
Manual Functions -	Non-automated activities.
Medicaid Card -	Identification card used to obtain medical services by Medicaid recipients.
Medically Needy -	Those individuals otherwise eligible for Medicaid whose income and resources are above the limits prescribed for receipt of cash payment but are within the limits set under the Medicaid State plan.
MEDIRS -	Medicaid Eligibility Determination and Information Retrieval System (HCFA)
MMIS -	Medicaid Management Information System; an automated Medicaid provider bill payment system (HCFA).
MNIL -	Medically needy income level.
Multiprogram -	Involving more than one Federal entitlement program.
OAA -	Old Age Assistance.
OASDI -	Old Age, Survivors and Disability Insurance Benefits (SSA).
Off Loading -	Removal of data from on-line storage to another storage medium.

OMB Instruction -	A legally enforceable directive issued by the U.S. Office of Management and Budget.
On-Line -	Equipment directly controlled by the computer's central processing unit; computerized data directly available to the user.
Operational -	The point in time a new system is satisfactorily tested and begins to routinely handle the system functions.
Output -	Data being delivered or to be delivered from a device or from a computer program.
Parallel Operation -	The simultaneous processing of individual pieces of information from a single source using separate facilities for the simultaneous processing.
Phased Approach -	The division of a system development project into distinct parts or phases and the staggered implementation of the phases to enable a State to receive some benefits from the system before the entire system is completed.
PL -	Federal Public Law.
Privacy Act -	A Federal law designed to protect data collected for Federal purposes from unauthorized access.
Project Milestones -	Points during system development at which an important task or a phase should be completed or examined to resolve significant problems.
QC -	Quality Control.
Quantifiable Benefits -	Positive results of system operation which can be physically measured.
Recipient -	A person determined eligible to receive Medicaid benefits - may be synonymous with claimant.
Redetermination -	The periodic review of a recipient's situation to determine whether the recipient's eligibility should continue, terminate or be adjusted in some way.

Regional Offices -	Offices of DHHS or HCFA having responsibility for specific geographic areas, e.g., the N.Y. Region is responsible for N.Y., N.J., Puerto Rico and the Virgin Islands.
Restart -	The ability to reactivate a computer system following maintenance, repair of a malfunction or the loss of electrical power.
Restore -	The ability to replace data lost or damaged during a malfunction or other event resulting in disruption of computer operations.
RFP -	Request for proposal; a device used by government agencies to solicit contractor bids prior to award of a contract.
SDX -	State Data Exchange; SSA's medium for the transfer of SSI entitlement information to State Medicaid offices.
Secretary (the) -	The Secretary of the Department of Health and Human Services.
Security -	The protection of data, hardware and software from unauthorized access and physical damage.
Software -	A set of programs, procedures and associated documentation concerned with the operation of a data processing system.
Software Conversion -	The adaptation of software designed to operate on a specific type of computer equipment into a form able to operate on another type of computer equipment.
Special Income Level -	That standard established by the State for individuals in institutions who would be eligible for AFDC, SSI, or State supplements except for their institutional status.
Spenddown -	A process whereby Medicaid eligibility may be established if an individual's income is more than that allowed under the State's standards and incurred medical expenses are at least equal to the difference between the income and the medically needy income standard.

SS-5 -	An application form for a Social Security Account Number or Card.
SSA (Act) -	The Social Security Act.
SSA (Administration) -	The Social Security Administration.
SS Card -	Social Security card.
SSI -	Supplemental Security Income.
SSN -	Social Security Number.
State Supplement -	An optional or mandatory amount of money in excess of Federal payments sent to certain SSI recipients by some States (or by the Federal Government under agreement with a State). Some persons may qualify for a State supplement but not receive a Federal SSI payment.
Statewide -	A centralized system or program operated in the same manner in every jurisdiction in a State.
System -	In data processing, a collection of people, machines, and methods organized to accomplish a set of specific functions.
Terminals -	Cathode ray tubes, keyboards or other mechanized means of accessing the central Medicaid data base.
Third Party Liability - (TPL)	The responsibility of an insurance company, other government agency, employer, individual or party other than the Medicaid recipient or Medicaid agency to pay all or a portion of medical expenses.
Tickler File -	A clerical device whereby the date the next action is due is marked in a conspicuous location on the outside of a paper file or folder enabling those folders to be selectively removed from a file cabinet or other storage location.
USDA -	United States Department of Agriculture; administrator of the Food Stamp Program.
Useful Life of the System -	The number of years a system is expected to efficiently and effectively serve the needs of the State program(s).

Users -	Persons who interpret output, prepare input, and identify and specify requirements for systems design.
WIN -	Work Incentive Program.
IV-D -	Child Support Enforcement Program.

FUNCTIONAL REQUIREMENTS

CHAPTER 2

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15200. GENERAL

This chapter reflects HCFA's efforts to distill integrable functional requirements from Federal law and regulations. The information is for use by the States in developing Medicaid only or integrable multiprogram Medicaid eligibility determination and information retrieval systems.

15205. MANAGEMENT OVERVIEW

The functional requirements described are grouped into four major categories interacting with a statewide data base that supports all activities within the system.

1.0 Intake.— Incorpora [illegible] ies related to the collection and registration of new information concer [illegible] nants or recipients during the initial application process or subseque [illegible] n information from any source (including interfaces from other systems). [illegible] identification through the issuance or recall of a unique identifier and records control are established at this point.

2.0 Records Management.— Controls all activities related to the movement of information through the system and decision making. These functions are critical to the effective operation of the eligibility determination system to ensure the accuracy of data necessary for the operation of the other functional categories.

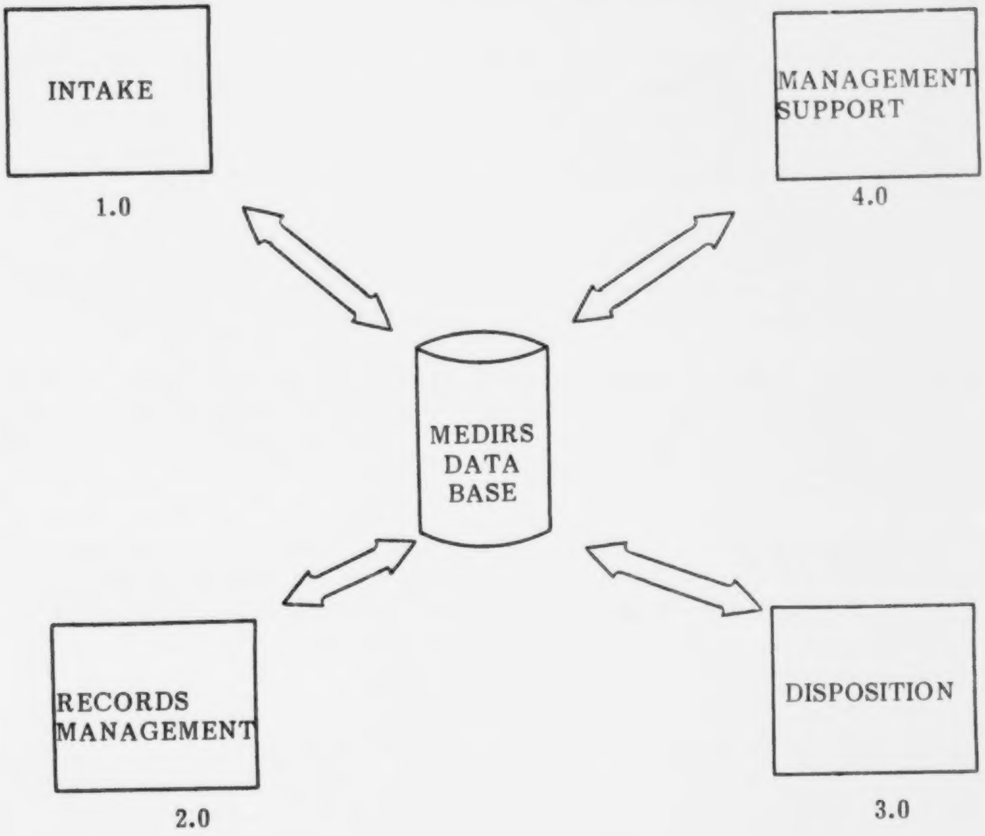
3.0 Disposition.— This encompasses all activities involving notification, referral and benefit delivery. Intake information is evaluated and measured against program criteria to determine whether the claimant is eligible for benefits. It also includes the automated transfer of data to other systems and the release of decision notices to the claimant.

4.0 Management Support.-- Includes all functions necessary to generate Federal and State Medicaid reports, including periodic reports, and special purpose ad hoc reports for the support of statistical, fiscal, and management requirements.

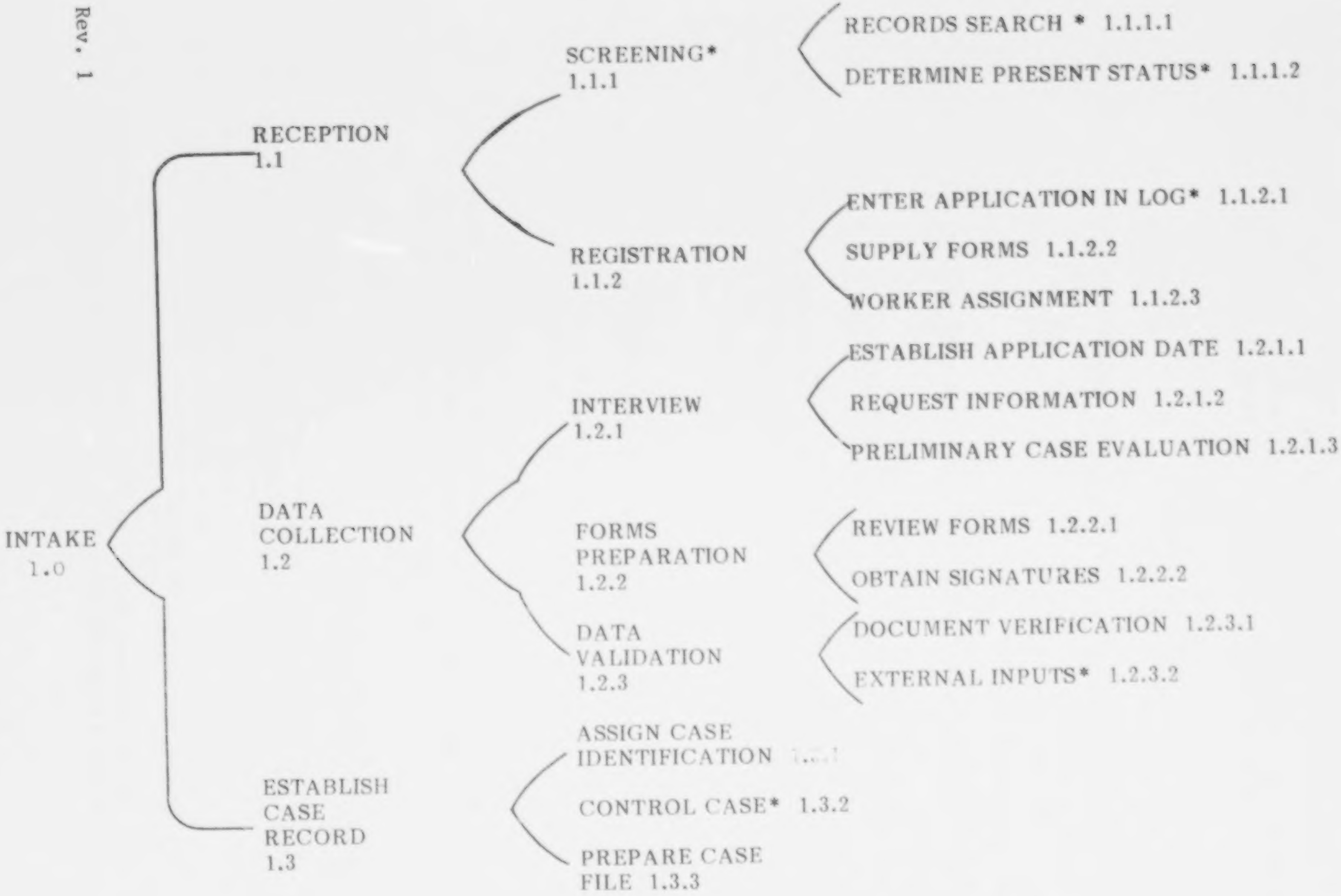
15210. DATA BASE

An integrated data base supplies the data necessary to operate the automated functional requirements. This data base consists of all the data files which support MEDIRS. The data from each record should be grouped into smaller units or segments which can be selectively accessed by a data processing module, but no specific structure is mandated for all States to follow. The exact type of structure - network, hierarchial, or relational - can influence design time required and future flexibility and each State is free to select the data base structure which best meets its needs. The data base design chosen should, however, have the flexibility to allow the automation of functions requiring automation plus any optional functions for which the State prefers automation.

15215. MEDIRS FUNCTIONAL DIAGRAM


INTAKE
1.0
MANAGEMENT SUPPORT
4.0
MEDIRS DATA BASE
RECORDS MANAGEMENT
2.0
DISPOSITION
3.0

15220. INTAKE


INTAKE 1.0
RECEPTION 1.1
SCREENING* 1.1.1
RECORDS SEARCH * 1.1.1.1
DETERMINE PRESENT STATUS* 1.1.1.2
REGISTRATION 1.1.2
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DATA COLLECTION 1.2
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ESTABLISH APPLICATION DATE 1.2.1.1
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DOCUMENT VERIFICATION 1.2.3.1
EXTERNAL INPUTS* 1.2.3.2
ESTABLISH CASE RECORD 1.3
ASSIGN CASE IDENTIFICATION 1.3.1
CONTROL CASE* 1.3.2
PREPARE CASE FILE 1.3.3

*AUTOMATION REQUIRED FOR APPROVAL OF ENHANCED FFP.
NOTE: THERE IS NO SEQUENTIAL OR TEMPORAL RELATIONSHIP.

1.1.1.1 RECORDS SEARCH

This function provides access to claimant data and identifies possible duplicate cases. The files are searched for prior records using a key identifier and qualifiers such as:

1. Claimant's name, SSN, date of birth (dob) and sex,
2. Child's name, SSN and sex, or
3. SSN, dob, address and sex

to locate potential matches. Appropriate action may then be taken in the event of a match.

1.1.1.2 DETERMINE PRESENT STATUS

Current eligibility status is determined upon completion of the records search, e.g.:

1. Never filed - not known to the agency,
2. Filed but application pending a determination,
3. Filed and denied benefits,
4. Currently active and receiving assistance,
5. Previously active but not currently - prior record exists, and
6. Currently active for another assistance program. This may eliminate the application process (42CFR435.909).

1.1.2.1 ENTER APPLICATION IN LOG

The application is registered in the system to provide a permanent record of the application date.

1.1.2.2 SUPPLY FORMS

The claimant is supplied the proper agency prescribed forms and provided needed instruction and assistance in completion of the forms (42 CFR 435.907 and 435.908). The claimant is also notified of documentation needed to verify eligibility.

1.1.2.3 WORKER ASSIGNMENT

This is the assignment of a Medicaid representative to a claimant for a specified task. It can involve the reassignment of a previously involved Medicaid representative or the assignment of a different representative.

1.2.1.1 ESTABLISH APPLICATION DATE

An appplication date is registered and a countdown is maintained to ensure that a decision is made within prescribed time limits. This time frame must not exceed 60 days for disabled claimants or 45 days for other claimants (42CFR435.911). This would also establish when eligibility begins and the dates for any retroactive coverage (42CFR435.913).

In the event of a policy change, this application date may determine which policy applies.

1.2.1.2 REQUEST INFORMATION

Case data are reviewed for completeness, accuracy and verification. Missing information is requested and the request date is recorded. A reminder notice may be sent if the information is not received timely, possibly establishing good cause for extension of the 45/60 day determination deadline (42 CFR 435.911(c)). Reminder notice dates are also recorded.

A specific request will be made for the SSN of each individual for whom Medicaid services are requested (42 CFR 435.910).

1.2.1.3 PRELIMINARY CASE EVALUATION

An initial evaluation is made based upon the current alleged status of the claimant. If the claimant appears eligible, the claimant is informed of any additional documentation required to verify eligibility. If the claimant is determined ineligible, the intake function is terminated and the appropriate written denial notice containing appeal rights is issued. Collected data are recorded (42 CFR 435.912).

Possible third party medical liability should be investigated and provisions made for assuring third party recovery (42 CFR 433.138).

Regardless of eligibility, the agency must furnish the following information in appropriate written or oral form to all applicants and to individuals who request it:

1. The eligibility requirements,
2. Available Medicaid services, including prepaid health plans, and
3. The rights and responsibilities of applicants and recipients.
   (42CFR435.905)

1.2.2.1 REVIEW FORMS

The application and associated forms are reviewed for accuracy and completeness. Checks are made to ensure the data are accurate, noncontradicting and coordinated with other appropriate agency programs. The application must be in writing from a claimant or someone acting responsibly for a claimant who is incompetent or incapacitated, and be on forms prescribed by the agency (42 CFR 435.907). The Medicaid case record must contain data to support the agency's determination (42 CFR 435.913).

1.2.2.2 OBTAIN SIGNATURES

The necessary assignments, authorizations, and applications must be signed on forms prescribed by the agency (42 CFR 435.907).

1.2.3.1 DOCUMENT VERIFICATION

This involves the corroboration of specific claimant information. The failure to receive needed information from a claimant, examining physician or other source may extend the 45/60 day determination deadline (42 CFR 435.911c). The specific reason(s) for a determination delay beyond 45 or 60 days must be recorded in the case record (42 CFR 435.911(d)).

1.2.3.2 EXTERNAL INPUTS

The addition of data to a claimant's record which is not directly reported by the claimant or the Medicaid agency, e.g., SDX, BENDEX, local records.

1.3.1 ASSIGN CASE IDENTIFIER

A unique identifier is assigned to an individual. This may be an SSN or any unduplicated identifier designated by the State. The SSN must be requested during the application process (42 CFR 435.910) and again during the redetermination (42CFR435.920) if not already included in the case record.

Local offices may also issue a separate case number to identify entitled family units residing within the local jurisdiction.

1.3.2 CONTROL CASE

Controls are maintained to support and monitor the timeliness of application processing, scheduled reviews and follow-ups for information. Controls may include tickler files, automated diaries, manual or automated case listings or other methods and must be initiated upon receipt of any data requiring additional action (42 CFR 435.916).

1.3.3 PREPARE CASE FILE

This encompasses all actions necessary to add a new case to the files.

15225. RECORDS MANAGEMENT

- RECORDS MANAGEMENT* 2.0
  - RECORD SELECTION* 2.1
    - IDENTIFY RECORD* 2.1.1
    - ACCESS RECORD* 2.1.2
  - RECORD MAINTENANCE* 2.2
    - EDIT CHANGE* 2.2.1
    - APPLY CHANGE* 2.2.2
    - EVALUATE* 2.2.3
      - ESTABLISH GENERAL/CATEGORICAL COVERAGE* 2.2.3.1
      - PREPARE SUMMARY REVIEW* 2.2.3.2
      - CALCULATE RESOURCES* 2.2.3.3
      - CALCULATE INCOME STATUS* 2.2.3.4
  - CLAIM DECISION* 2.3
    - COMPUTE BENEFITS* 2.3.1
    - ESTABLISH RECERTIFICATION DATE* 2.3.2

*** AUTOMATION REQUIRED FOR APPROVAL OF ENHANCED FFP.**

2.1.1 IDENTIFY RECORD

A reviewer must be able to locate specific records to verify, change or update information. The identification process for specific records can be simply to select one particular case or can require the application of an algorithm to select many cases, e.g., the use of an identification number to select one case, the selection of all cases with SSA income receiving cost of living increases, the selection of a specific category of cases needed for management purposes. Included in the selection process are cases for:

1. Scheduled redetermination,
2. Records for archival,
3. Selection of cases for special review, and
4. Records for QC review.

2.1.2 ACCESS RECORD

This involves the extraction of case data for review or update. It includes all the necessary precautions to ensure that the integrity of each record is maintained.

2.2.1 EDIT CHANGE

New datum is compared with existing datum to ensure accuracy and detect contradictions.

2.2.2 APPLY CHANGE

The validated change is applied to the record. This also controls prompt redetermination of eligibility when changes occur which may affect eligibility (42 CFR 435.916).

2.2.3.1 ESTABLISH GENERAL/CATEGORICAL COVERAGE

An individual receiving AFDC, SSI in a State with a 1634 agreement, a mandatory supplement or certain optional State supplements is automatically entitled to Medicaid without further evaluation (42 CFR 435.100 subpart B). The agency cannot require a separate Medicaid application (42 CFR 435.909).

States exercising options for the categorically needy or options for the medically needy, in accordance with Federal law and the individual State plan, must determine an individual's eligibility and coverage for Medicaid.

2.2.3.2 PREPARE SUMMARY REVIEW

This summarizes the eligibility data and results of computations for review by the claimant or Medicaid representative.

2.2.3.3 CALCULATE RESOURCES

The resources available to the claimant are compared to the allowable limits (42 CFR 435.721, 840, 841, 845).

2.2.3.4 CALCULATE INCOME STATUS

The appropriate income disregards are applied to the income available to the claimant. In medically needy cases an income spenddown amount is recorded for future comparison with medical bills (42 CFR 435 subparts G, H, I and 435.731(c)).

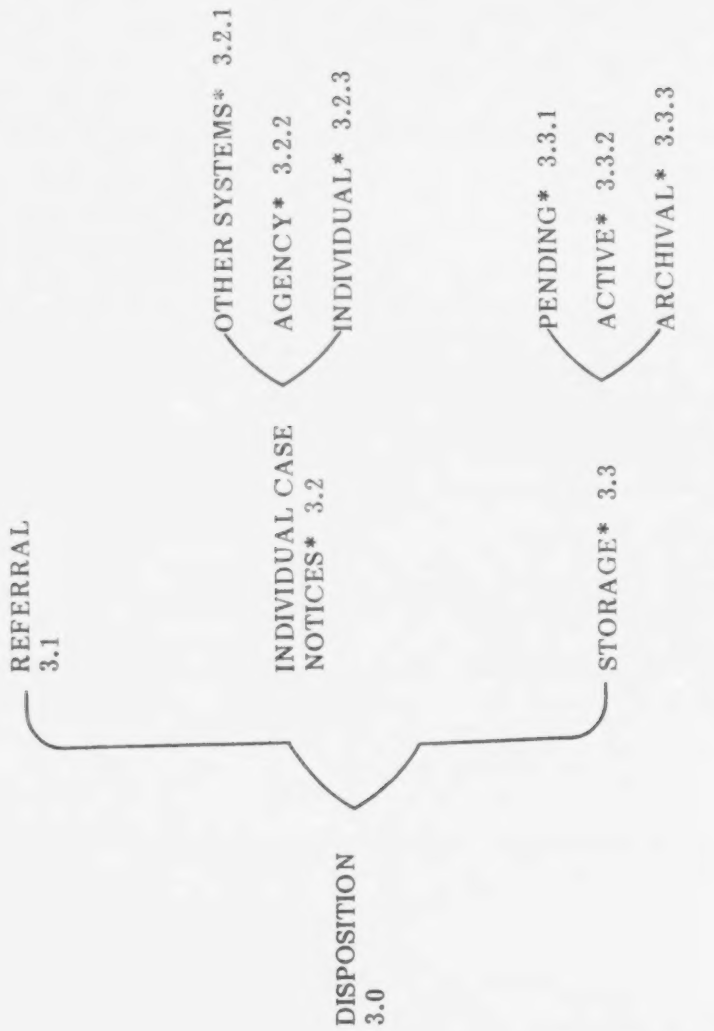
2.3.1 COMPUTE BENEFITS

This compares the countable income to the income standard under 42CFR435.812 through 435.816 to determine if the individual or family is eligible for Medicaid (42CFR435.831). It determines the amount of benefits available to those determined to be eligible as (1) medically needy, (2) categorically needy in institutions (42CFR435.725) and (3) aged, blind, or disabled in States using criteria more restrictive than SSI (42CFR435.732, 733).

2.3.2 ESTABLISH RECERTIFICATION DATE

Eligibility for Medicaid must be redetermined at least every 12 months (42CFR435.916). This function is incorporated into the control mechanism to ensure recertifications are accomplished as required. However, in medically needy cases, the agency must use a prospective financial computation of not more than 6 months (42CFR435.831).

15230. DISPOSITION


DISPOSITION
3.0
REFERRAL
3.1
INDIVIDUAL CASE
NOTICES* 3.2
OTHER SYSTEMS* 3.2.1
AGENCY* 3.2.2
INDIVIDUAL* 3.2.3
STORAGE* 3.3
PENDING* 3.3.1
ACTIVE* 3.3.2
ARCHIVAL* 3.3.3

* AUTOMATION REQUIRED FOR APPROVAL OF ENHANCED FFP.

3.1 REFERRAL

The agency should attempt to direct claimants to other programs to which entitlement may exist, e.g., social services, food stamps, other medical programs. The agency must help recipients obtain emergency medical care 24 hours a day, seven days per week (42 CFR 435.930(c)).

3.2.1 OTHER SYSTEM

This encompasses the exchange of eligibility and benefit data with authorized programs in a mutually acceptable exchange medium, e.g., MMIS, Buy-In. SSI, unemployment records, food stamps.

3.2.2 AGENCY

This concerns the forwarding of claimant information to other State units on a need-to-know basis.

3.2.3 INDIVIDUAL

This concerns claimant notices, requests for additional information about a case, system claim decisions, issuance of award letters and the release of Medicaid cards. If a denial, the system will generate the reason citing the regulatory basis for the denial and explain the claimant's appeal rights (42 CFR 435.912). Recipients must be given timely and adequate notice of proposed action to terminate, discontinue or suspend eligibility or to reduce or discontinue Medicaid services (42 CFR 435.919). As a minimum, Medicaid card issuance must be automated for enhanced FFP. Other issuances should be automated to the extent possible.

3.3.1 PENDING

This allows for the storage of data from applications awaiting determinations of entitlement.

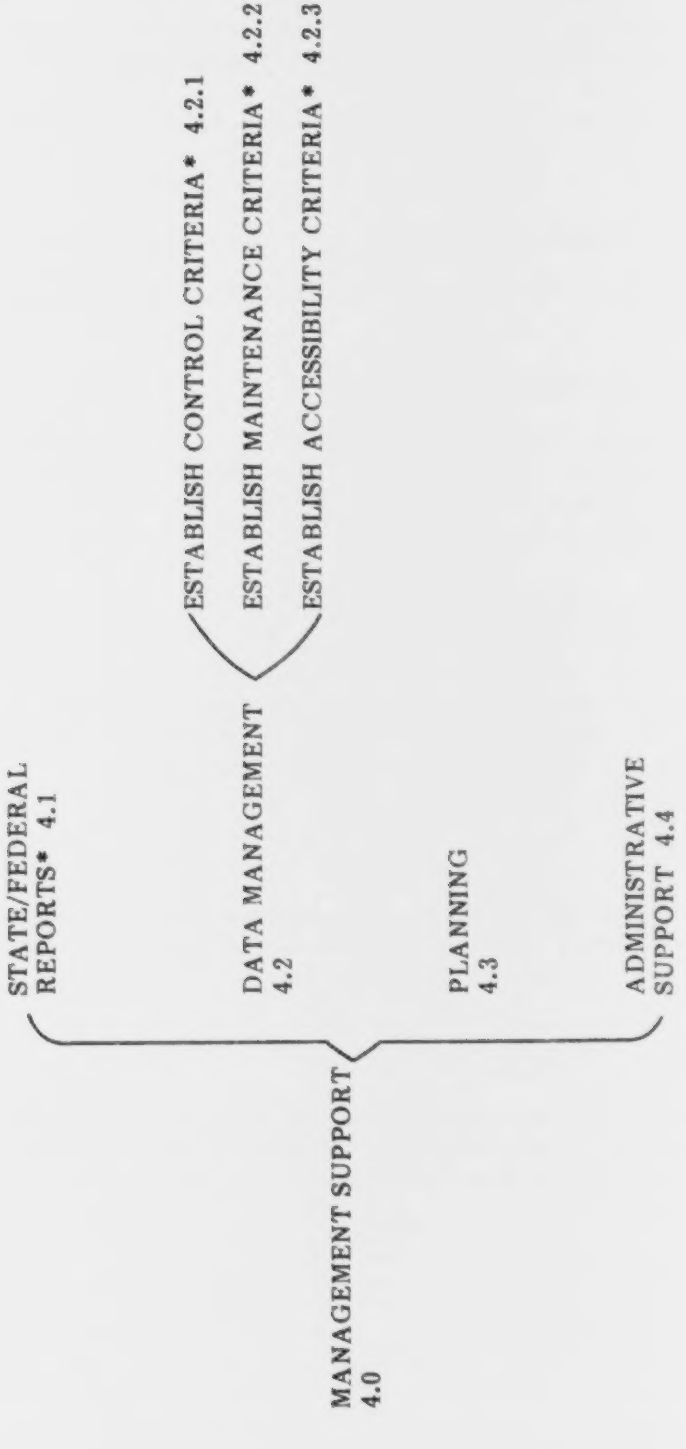
3.3.2 ACTIVE

This provides for the storage, location and access of data on current recipients including spenddown recipients.

3.3.3 ARCHIVAL

This provides for the deletion of inactive records or portions of records from the active files, e.g., denial cases, terminated cases. This reduces the size of the data base to improve processing and storage efficiency. The inactive records are stored in an archive medium to allow any needed subsequent access.

15235. MANAGEMENT SUPPORT


MANAGEMENT SUPPORT 4.0
STATE/FEDERAL REPORTS* 4.1
DATA MANAGEMENT 4.2
ESTABLISH CONTROL CRITERIA* 4.2.1
ESTABLISH MAINTENANCE CRITERIA* 4.2.2
ESTABLISH ACCESSIBILITY CRITERIA* 4.2.3
PLANNING 4.3
ADMINISTRATIVE SUPPORT 4.4

* AUTOMATION REQUIRED FOR APPROVAL OF ENHANCED FFP.

4.1 STATE/FEDERAL/LOCAL REPORTS

This supports the generation of hard copy report data for State, Federal or local reporting. (It is not reasonable to break the system into lower level report functions at this general level because of the variant State and local procedures and requirements. The number of, and specifications for, reports depend upon the individual State).

The two basic types of reports are those generated on a periodic basis and those generated on demand.

4.2.1 ESTABLISH CONTROL CRITERIA

This encompasses the control of physical records and the recovery of lost records.

4.2.2 ESTABLISH MAINTENANCE CRITERIA

This provides for the maintenance of claimant and recipient data in a current and accurate condition to support Medicaid activities. It ensures that adequate back-up files are maintained as a safety precaution in case of inadvertent destruction or during periods when equipment is inoperable.

4.2.3 ESTABLISH ACCESSIBILITY CRITERIA

This provides that only those persons with a "need to know" have access to data, e.g., certain State personnel, providers. Certain recipient data must be limited to select users. All data must be protected from unauthorized access. It protects data against accidental or unauthorized disclosure and from unauthorized modifications.

4.3 PLANNING

The development of processing and control data to evaluate efficiency, staffing requirements, provide audit trails and to assist in the identification of future requirements.

4.4 ADMINISTRATIVE SUPPORT

This supports certain agency internal services required in the administration of welfare programs. Specific functions are not addressed because they are not in the mainstream of operations and because they must reflect individual agency practices.

DATA REQUIREMENTS

CHAPTER 3

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15300. BACKGROUND

Eligibility determination and the collection and maintenance of eligibility information have been difficult and cumbersome tasks for most States. The amount of information required for any given eligibility program, variations of definitions between programs and requirements to verify information submitted by recipients place substantial burdens on local office workers and State agencies. Collection and maintenance of data in hardcopy files and manual processes increase both workloads and the potential for costly errors. Recent legislative actions impose substantial penalties on States if eligibility error rates are not controlled. In response to these problems, States are increasingly looking to electronic or automated systems to rationalize the multiplicity of definitions imposed by varying program requirements, ease the workload on local office workers, reduce the number of times data must be transcribed, and reduce error rates.

The information presented in the following two chapters reflects HCFA's development of data requirements and data elements based solely on Federal law and regulations for State use in developing Medicaid eligibility systems. The information may be used either in a "stand-alone" system or as part of an integrated multi-program system for those public assistance programs that impact on the Medicaid program.

These chapters contain a compilation of the laws, regulations, and instructions to States supporting information collection, processing, and reporting needs for Medicaid eligibility determinations systems. As such, the document forms the principal basis for identifying the functions and data necessary to determine and maintain Medicaid eligibility, and to provide accurate and timely information used to provide coverage and pay claims on behalf of eligible individuals.

A difficult task for most State agencies is the development and compilation of data elements reflecting Federal law and regulation. Current regulations are widely dispersed under a number of CFR references. Although HCFA has attempted to locate Medicaid-specific eligibility regulations within 42 CFR 435, many regulatory requirements impacting on title XIX eligibility are contained in the regulations for the categorical programs. Eligibility for AFDC also confers eligibility for Medicaid. Individuals meeting SSI eligibility requirements or meeting more restrictive aged, blind, and disabled standards (in some States) are also eligible for Medicaid. Eligibility requirements for AFDC are largely contained in 45 CFR, and for SSI in 20 CFR.

The regulations for determining categorical eligibility are necessary to determine eligibility for the optional Medicaid programs, including the Medically Needy. These regulations, from 20 and 45 CFR, must be used in conjunction with the Medicaid eligibility determination regulations contained in 42 CFR.

The requirements identified in this section are extracted from the regulations and represent the principal eligibility requirements necessary to identify recipients eligible for Medicaid services. As the compilation is an extract, it should not be taken or assumed, to replace or supplant the regulatory document from which it is derived. The requirements are organized in four segments or sections, as follows:

A. General Eligibility Requirements.— the requirements that apply to all cases and reflect the data necessary to provide medical assistance.

B. Categorical Requirements.— the requirements that reflect the various standards used in determining the categorical program and kinds and levels of benefits available.

C. Coverage Groups.— identify the various mandatory and optional Medicaid coverages available for States.

D. Financial Requirements.— reflect the income, resource, and disregard standards that must be met.

The requirements listed in this chapter are cross-referred to the data elements needed to support the data requirements. The cross-reference number indicates the number of the data element or elements in the Data Element Dictionary. (NOTE: The third segment, Coverage Groups, does not have cross-references as it designates categories of entitlement and, as such, does not contain specific requirements.)

15310. GENERAL DATA REQUIREMENTS

A. NAME

DEFINITION: The individual under whose name the record is established.

VERIFICATION: Birth certificate, driver's license, statement or other proof of identity

CITATION: 42CFR435.907

CROSS REFERENCE: 1.01, 2.08

B. DATE OF BIRTH

DEFINITION: The date upon which the individual was born.

VERIFICATION: Birth certificate, baptism certificate, school records, other acceptable means of birth date verification.

CITATION: 42CFR435.401, 42CFR435.403, 42CFR435.520

CROSS REFERENCE: 1.02

C. SEX

DEFINITION: Male, Female

VERIFICATION: Worker's observation, recipient's statement

CITATION: 42CFR435.910

CROSS REFERENCE: 1.04

D. RACE OR ETHNIC GROUP

DEFINITION: Self-explanatory

VERIFICATION: Observation, recipient's statement, immigration papers or similiar documentation. May not require verification.

CITATION: OMB Instruction 113-1 Appendix A

CROSS REFERENCE: 1.05

E. MARITAL STATUS

DEFINITION: Single, married, divorced, widowed, or separated

VERIFICATION: Legal or religious documents

CITATION: 42CFR435.821

CROSS REFERENCE: 1.06

F. EMPLOYMENT STATUS

DEFINITION: Employed, unemployed, registered for work, in training

VERIFICATION: Pay stubs, lay-off or separation notice, work registration card

CITATION: 42CFR435.831

CROSS REFERENCE: 1.07, 1.08, 2.03 - 2.07, 2.10

G. SOCIAL SECURITY NUMBER

DEFINITION: Disclosure of the SSN may be made mandatory only if the State had in existence and operating prior to January 1, 1975, a system of welfare or Medicaid records for which disclosure of the SSN was required, by statute or regulation, in order to verify the identity of the individual. If any individual cannot provide a SSN either because he has not been issued one or he does not know his SSN, and wishes to secure one, the agency shall assist him in filing an application for a number. Under this requirement, the agency also obtains such evidence as may be required under SSA regulations to establish the age, citizenship or alien status, and true identity of such applicant, and where the case record attests that a previous social security number has been issued, requests verification of the number by SSA. Where disclosure of the SSN is voluntary, no individual who is otherwise eligible shall be denied assistance because of failure or refusal to disclose or apply for a SSN, and the individual shall be so informed. The agency shall not deny or delay assistance to an eligible individual pending issuance by SSA or verification by the agency of his SSN.

VERIFICATION: SS Card, SS-5

CITATION: 42CFR435.910, 45CFR232.10, 45CFR206.10 (a) (1) (vi) (b) (c)

CROSS REFERENCE: 1.20, 1.46, 2.09

H. HEALTH INSURANCE CLAIM NUMBER

DEFINITION: The claim number (CAN) is the social security number (SSN) of the individual on whose earnings record benefits (if any) are being paid followed by an alpha or alpha and numeric suffix. The number may or may not be the same as the individual's SSN. This category includes Railroad Retirement numbers with prefixes.

VERIFICATION: BENDEX, SDX, Medicare card

CITATION: 42CFR433.135, SSA 1902(a)(15)

CROSS REFERENCE: 1.21

I. MAILING ADDRESS

DEFINITION: Place for receipt of mail

VERIFICATION: Client's statement

CITATION: 42CFR435.912

CROSS REFERENCE: 1.23

J. RESIDENT ADDRESS:

DEFINITION: Place of residence

VERIFICATION: Client's statement

CITATION: 42CFR435.912

CROSS REFERENCE: 1.24

K. LIVING ARRANGEMENT OF CHILD UNDER AFDC

DEFINITION: Child must be living with a relative specified by law in a place of residence maintained by such relative as his own home in order to be eligible for AFDC: Father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepsister, uncle, aunt, first cousin, nephew or niece, or child may be living in a foster family home or child care institution as a result of a voluntary agreement with a relative or a judicial determination and the child had received aid in or for the month in which the agreement was entered into or court proceedings initiated.

K. LIVING ARRANGEMENT OF CHILD UNDER AFDC (Cont.)

VERIFICATION: Recipient's statement, birth certificate, court order or decree, school records

CITATION: SSA 406(a)

CROSS REFERENCE: 1.09, 1.10, 1.25, 2.11

L. CITIZENSHIP

DEFINITION: Recipient should be a citizen or alien lawfully admitted for permanent residence, or permanently residing in this country under color of law. (Includes legally admitted refugees.)

VERIFICATION: Birth certificate, citizenship, or immigration papers

CITIATION: 42CFR435.402

CROSS REFERENCE: 1.30, 1.31

M. RESIDENCY

DEFINITION: A resident of a State is an individual who intends to remain in the State permanently or for an indefinite period or entered with a job commitment or seeking employment.

For institutionalized individuals under age 21 or who are age 21 or older and became incapable of indicating intent before age 21, the State of residence is:

> The State where the institution is located unless that State determines the individual to be a resident of:
>
> - his parents' State of residence, or his legal guardian's if one has been appointed; or
> - the parent's State of residence who applies for Medicaid on behalf of the individual.

For any other institutionalized individual who became incapable of indicating intent at or after age 21, the State of residence is the State where the institution is located unless that State determines the individual to be a resident of:

- the State where he was living when he became incapable, or if this cannot be determined;
- the State where he was living when he was first determined to be incapable.

M. RESIDENCY (Cont.)

VERIFICATION: Resident's address statement, guardianship papers, parents' address, and physician records

CITATION: 42CFR435.403

CROSS REFERENCE: 1.32, 1.33, 1.34, 1.35

N. CHOICE OF CATEGORY

DEFINITION: Individual permitted to select category if eligible under more than one category

VERIFICATION: Statement by recipient

CITATION: 42CFR435.404

CROSS REFERENCE: 1.36

O. INITIAL DATE OF CONTACT

DEFINITION: The agency must afford an individual wishing to do so the opportunity to apply for Medicaid without delay. It is the date of applicant's first contact with agency.

VERIFICATION: N/A

CITATION: 42CFR435.906

CROSS REFERENCE: 1.40

P. APPLICATION DATE

DEFINITION: The agency must require a written application from the applicant, an authorized representative or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant. The application must be on a form prescribed by the agency, signed under a penalty of perjury and dated.

VERIFICATION: Signed application

CITATION: 42CFR435.907

CROSS REFERENCE: 1.29, 1.41

Q. DISPOSITION DATE

DEFINITION: (a) The agency must establish time standards for determining eligibility and inform the applicant of what they are. These standards may not exceed -(1) Sixty days for applicants who apply for Medicaid on the basis of disability; and (2) Forty-five days for all other applicants. (b) The time standards must cover the period from the date of application to the date the agency mails notice of its decision to the applicant.

VERIFICATION: Authorization or denial letter

CITATION: 42CFR435.911

CROSS REFERENCE: 1.42

R. ELIGIBILITY EFFECTIVE DATE

DEFINITION: (a) The agency must make eligibility for Medicaid effective no later than the third month before the month of application if the individual - (1) Received Medicaid services, at any time during that period, of a type covered under the plan; and (2) Would have been eligible for Medicaid at the time he received the services if he had applied (or someone had applied for him), regardless of whether the individual is alive when application for Medicaid is made. (b) The agency may make eligibility for Medicaid effective on the first day of a month if an individual was eligible at any time during that month. (c) The State plan must specify the date on which eligibility will be made effective.

VERIFICATION: Signed application, evidence of covered services in prior months, documentation of eligibility requirements being met

CITATION: 42CFR435.914

CROSS REFERENCE: 1.43

S. REDETERMINATION DATE

DEFINITION: (a) The agency must redetermine the eligibility of Medicaid recipients with respect to circumstances that may change, at least every 12 months. In medically needy situations, the agency must use a prospective financial computation of not more than 6 months. However, (1) the agency may consider blindness as continuing until the review physician determines in accordance with standards in 435.531 that a recipient's vision has improved beyond the definition of blindness contained in the plan; and (2) the agency may consider disability as continuing until the review physician determines in accordance with standards in 435.541 that a recipient's disability no longer meets the definition of disability contained in the plan.

S. REDETERMINATION DATE

VERIFICATION: Authorization letter

CITATION: 42CFR435.831, 42CFR435.916

CROSS REFERENCE: 1.45

T. TERMINATION DATE

DEFINITION: (a) The agency must give recipients timely and adequate notice of proposed action to terminate, discontinue, or suspend their eligibility or to reduce or discontinue services they may receive under Medicaid. This notice must be mailed at least 10 days before the date of the action.

VERIFICATION: Authorization letter

CITATION: 42CFR435.919, 42CFR431.211

CROSS REFERENCE: 1.44

U. SSN VERIFICATION

DEFINITION: (a) In redetermining eligibility, the agency must review case records to determine whether they contain the recipient's SSN or, in the case of families, each family member's SSN. (b) If the case record does not contain the required SSNs, the agency must request them and meet other requirements of 435.910. (c) For any recipient whose SSN was established as part of the case record without evidence required under the SSA regulations as to age, citizenship, alien status, or true identity, the recipient must provide verification of these factors in accordance with 435.910.

VERIFICATION: N/A

CITATION: 42CFR435.920

CROSS REFERENCE: 1.46

V. E.P.S.D.T. - Early and Periodic Screening, Diagnosis, and Treatment for AFDC Individuals Under 21

DEFINITION: The Social Security Act, Section 1905 (a)(vii)(4)(B) prescribes State plan requirements for providing early and periodic screening and diagnosis of eligible Medicaid recipients under 21 to ascertain physical and mental defects, and providing treatment to correct or ameliorate defects and chronic conditions found.

V. E.P.S.D.T. - Early and Periodic Screening, Diagnosis, and Treatment for AFDC Individuals Under 21 (Cont.)

VERIFICATION: State record

CITATION: 42CFR441.50

CROSS REFERENCE: 1.71, 1.72, 1.73

15320. CATEGORICAL DATA REQUIREMENTS

A. DEPENDENCY

DEFINITION: An individual under age 18, or, at State option, under 19 (but only if the child is a full-time student in a secondary school or the equivalent level of technical training, and may reasonably be expected to complete the program before he reaches age 19) deprived of parental support or care, who is an eligible member of a family with dependent children.

VERIFICATION: Varies according to State plan, statement of applicant, and other proofs as required

CITATION: 42CFR435.510, SSA 1902(b)(2), 45CFR233.20

CROSS REFERENCE: 1.25, 2.01 - 2.12

B. AGE

DEFINITION: 1. The agency must not impose an age requirement that excludes an individual under age 19 who meets the definition of dependent child under the State title IV-A plan; or a lower age requirement than that under the State's AFDC plan.

Must use popular usage method of determining age, if used in State AFDC plan. Otherwise common law method must be used.

If year, but not month and day is known, may use July 1, as birthday.

2. No State plan may be approved for FFP if an age requirement of more than 65 years is imposed.

Federal determination of whether an individual meets the age requirements of the Social Security Act will be made according to the common law method (under which a specific age is attained the day before the anniversary of birth), unless the State is a 209(b) State and specifies that the popular usage method is used, or that the determination of age by SSI is used.

B. AGE (Cont.)

DEFINITION (Cont.):The State agency may adopt an arbitrary date such as July 1 as the point from which age will be computed in all instances where the month of an individual's birth is not available, but the year can be established.

VERIFICATION: Birth certificate, Baptismal records, school records

CITATION: 42CFR435.520, SSA 1614(a), SSA 1905 (a)(vii)(4)(B)

CROSS REFERENCE: 1.02, 1.09, 1.71

C. BLINDNESS

DEFINITION: For the purpose of determining SSI benefits, an individual is blind if: (1) he has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens, (2) he is blind as defined under a State plan approved under title X or title XVI of the Act as in effect for October 1972 and received aid under such plan (on the basis of blindness) for December 1973 so long as he is continuously blind.

Blind persons under age 65 must be referred for vocational rehabilitation. No examination is necessary when both eyes are missing.

To be eligible for Medicaid, applicants must meet the State definition of blindness, or the same definition as used in SSI.

In any instance in which a determination is to be made whether an individual is blind or continues to be blind as defined under the State plan, an initial examination or reexamination will be performed by either a physician skilled in the diseases of the eye or by an optometrist, whichever the individual selects.

VERIFICATION: Medical statement, other records as needed

CITATION: 42CFR435.530, SSA 1614(a)(2)

CROSS REFERENCE: 2.31, 2.34

D. DISABILITY

DEFINITION: The Social Security Administration or the State review team determines eligibility for medical disability based on the Federal definition after review of medical and social reports.

An individual is eligible for SSI if he is permanently and totally disabled as defined under title XIV or XVI of the Act as in effect for October 1972 and received aid under such a plan (on the basis of disability) for December 1973, and for at least one month prior to July 1973 so long as he is continuously disabled as defined.

D. DISABILITY (Cont.)

DEFINITION (Cont.): To be eligible for Medicaid, applicants must meet the State definition for disability, or the same definition as used in SSI.

VERIFICATION: Medical substantiation

CITATION: 42CFR435.540, SSA 1614(a)(3)

CROSS REFERENCE: 2.41, 2.44

15330. COVERAGE GROUPS

15331. MANDATORY COVERAGE

A. AFDC RECIPIENT

DEFINITION: Individuals receiving payments under title IV-A are eligible for Medicaid.

VERIFICATION: State and county records

CITATION: 42CFR435.110

B. DEEMED AFDC RECIPIENT NOT RECEIVING CASH PAYMENT OF LESS THAN $10.00

DEFINITION: The agency must provide Medicaid to individuals deemed to be receiving AFDC who are denied a cash payment solely because the amount would be less than $10.00.

VERIFICATION: State and county records

CITATION: 42CFR435.115(a)

C. PREGNANT WOMEN DEEMED TO BE RECEIVING AFDC

DEFINITION: The State may deem a pregnant woman to be receiving AFDC if she would be eligible for AFDC cash payments if the child had been born and the pregnancy has been medically verified. The agency must provide Medicaid to deemed AFDC recipients.

VERIFICATION: State and county records

CITATION: 42CFR435.115(c)

D. PARTICIPANTS IN WORK SUPPLEMENTATION PROGRAM DEEMED TO BE RECEIVING AFDC

DEFINITION: The State may deem participants and any child or relative of the participant in a work supplementation program to be receiving AFDC if the individual participates in a State operated program and would be eligible for an AFDC cash payment if the individual were not in the program. The agency must provide Medicaid to deemed AFDC recipients.

VERIFICATION: State and county records

CITATION: 42CFR435.115(d)

E. AFDC FAMILIES TERMINATED BECAUSE OF INCREASED EARNINGS OR HOURS OF EMPLOYMENT

DEFINITION: (a) If a family loses AFDC because of increased income from employment or increased hours of employment, the agency must continue to provide Medicaid for 4 months to all members of the family if (1) the family received AFDC in any 3 or more months during the 6-month period immediately before the month in which it became ineligible for AFDC; and (2) at least one member of the family is employed throughout the 4 calendar months although this need not be the same member for the whole period.
(b) The 4 calendar months begin on the date AFDC is terminated. If AFDC benefits are terminated retroactively, the 4-month period also begins retroactively with the first month in which AFDC was erroneously paid.

VERIFICATION: State and county records

CITATION: 42CFR435.112

F. INDIVIDUALS INELIGIBLE FOR AFDC DUE TO PROVISIONS PROHIBITED BY TITLE XIX

DEFINITION: The agency must provide Medicaid to individuals who would be eligible for AFDC except for an eligibility requirement used in that program that is specifically prohibited under title XIX.

VERIFICATION: Case record

CITATION: 42CFR435.113

G. SOCIAL SECURITY BENEFICIARY

DEFINITION: (1) Any individual as of August 1972, receiving or eligible to receive OASDI and public assistance in any one of the categories of OAA, AB, APTD, AABD, or AFDC who would otherwise lose eligibility due to the increase in Social Security benefits under PL 92-336. Any individual who would have been eligible for

G. SOCIAL SECURITY BENEFICIARY (Cont.)

DEFINITION (Cont.): one of those programs except that he had not applied, and the Medicaid plan covered this optional group, would have been eligible if he were not in a medical institution or intermediate care facility and the Medicaid plan covered this optional group, or would currently be eligible for SSI or State supplement except for the OASDI increase. (2) Any individual receiving SSI or optional State supplement and is receiving OASDI. (3) Any individual who was receiving SSI or optional State supplements but became ineligible for those payments because of the OASDI cost-of-living increase paid after April 1977.

VERIFICATION: Letter of entitlement, SDX, State or county records

CITATION: 42CFR435.114, 134, 135, SSA 1902(a)

H. SSI BENEFICIARY

DEFINITION: Recipients receiving SSI as aged, blind, or disabled, if the State uses SSI standards for determining eligibility for Medicaid.

VERIFICATION: SSI Award Notice, SDX

CITATION: 42CFR435.120

I. RECIPIENT IN 209(b) STATE (Section 1902(f) of the Act)

DEFINITION: The agency may use Medicaid eligibility requirements for the aged, blind, or disabled that are more restrictive than the eligibility requirements for SSI. If an agency uses more restrictive requirements under this section(1) Each requirement may be no more restrictive than that in effect under the State's Medicaid plan on 1/1/72, and no more liberal than that applied under SSI or an optional State supplement program that meets the conditions of 435.230; and (2) In determining financial eligibility of an individual in the category to which the more restrictive requirements apply, the agency must deduct, from the individual's income, his SSI payment, any optional supplement paid under a program described in 435.230, and incurred medical expenses as specified in 435.732. (c) The following sections of this part apply to the agency's use of more restrictive eligibility requirements: Sections 435.135, 530, 540, 731 through 733, 812, 814, 823, 831, and 841.

VERIFICATION: SSI award notice, SDX

CITATION: 42CFR435.121

J. INDIVIDUALS INELIGIBLE FOR SSI OR OPTIONAL STATE SUPPLEMENTS DUE TO PROVISIONS WHICH ARE PROHIBITED BY TITLE XIX

DEFINITION: The agency must provide Medicaid to individuals who would be eligible for SSI or optional State supplements except for an eligibility requirement used in those programs that is specifically prohibited under title XIX.

J. INDIVIDUALS INELIGIBLE FOR SSI OR OPTIONAL STATE SUPPLEMENTS DUE TO PROVISIONS WHICH ARE PROHIBITED BY TITLE XIX (Cont.)

VERIFICATION: SDX

CITATION: 42CFR435.122

K. RECIPIENTS OF MANDATORY SUPPLEMENT PAYMENTS

DEFINITION: The agency must provide Medicaid to individuals receiving mandatory State supplements.

VERIFICATION: SDX, case record

CITATION: 42CFR435.130

L. INDIVIDUALS ELIGIBLE AS ESSENTIAL SPOUSES IN 12/73

DEFINITION: Any person eligible as an essential spouse of an aged, blind, or disabled cash assistance recipient in 12/73, will continue to be eligible thereafter for each month that he/she continues to meet the eligibility standards that were in effect in 12/73 concerning essential persons.

VERIFICATION: Case record

CITATION: 42CFR435.131, SSA 1905(a)

M. INSTITUTIONALIZED INDIVIDUALS ELIGIBLE IN 12/73

DEFINITION: Medicaid must be provided to individuals who were eligible in 12/73 as inpatients of facilities that were participating in the Medicaid program and who continue to meet the requirements in effect under the State's plan in 12/73 for institutionalized individuals, who have been institutionalized without interruption since 12/73, and continue to need institutional care.

VERIFICATION: Case record

CITATION: 42CFR435.132

N. BLIND AND DISABLED - ELIGIBLE IN 12/73

DEFINITION: Persons who were eligible for Medicaid in 12/73 as blind or disabled individuals are entitled to continued Medicaid coverage, even though they may not meet the eligibility conditions imposed by the state beginning in 1/74 for coverage of the blind and disabled, as long as blindness or disability have continued without interruption since 12/73 and all eligibility criteria are met for each consecutive month after 12/73.

N. BLIND AND DISABLED - ELIGIBLE IN 12/73 (Cont.)

VERIFICATION: SDX, case record

CITATION: 42CFR435.133

O. ADOPTION ASSISTANCE AND FOSTER CARE CHILDREN

DEFINITION: Children who have been adopted or placed in foster care and qualify for assistance under title IV-E of the Act.

VERIFICATION: State record

CITATION: 42CFR435.118

15332. OPTIONAL COVERAGE

A. INDIVIDUALS WHO WOULD BE ELIGIBLE FOR AFDC, SSI OR OPTIONAL STATE SUPPLEMENT BUT WHO ARE NOT RECEIVING BENEFITS

DEFINITION: Individuals or families who would be eligible for cash assistance under the categorical programs, but do not receive such benefits.

VERIFICATION: Case record

CITATION: 42CFR435.210

B. INDIVIDUALS WHO WOULD BE ELIGIBLE FOR CASH ASSISTANCE EXCEPT FOR THEIR INSTITUTIONAL STATUS

DEFINITION: Individuals in medical institutions and ICF.'s who are ineligible for AFDC, SSI or an optional State supplement because of lower income standards used to determine eligibility for institutionalized individuals but who would be eligible if not institutionalized.

VERIFICATION: Proof of institutionalized status

CITATION 42CFR435.211

C. INDIVIDUALS ELIGIBLE FOR AFDC WHEN CHILD CARE COSTS ARE PAID FROM EARNINGS

DEFINITION: The agency may provide Medicaid to individuals who would be eligible for AFDC if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure. The agency may use this option only if the State's AFDC plan deducts work-related child care costs from income to determine the amount of AFDC.

C. INDIVIDUALS ELIGIBLE FOR AFDC WHEN CHILD CARE COSTS ARE PAID FROM EARNINGS (Cont.)

VERIFICATION: Case record

CITATION: 42CFR435.220

D. CHILDREN UNDER 21 WHO WOULD BE ELIGIBLE FOR AFDC BUT DO NOT QUALIFY AS DEPENDENT CHILDREN

DEFINITION: The agency may provide Medicaid to individuals under age 21 (or, at State option, under 20, 19, or 18) who would be eligible for AFDC if they met the definition of dependent child. The agency may cover all such individuals or reasonable classifications of those individuals. Reasonable classifications include:

(a) Individuals in foster homes or private institutions for whom a public agency is assuming a full or partial responsibility.

(b) Individuals in adoptions subsidized in full or part by a public agency.

(c) Individuals in intermediate care facilities, if intermediate care facility services are provided under the plan.

(d) Individuals under age 21 receiving treatment in psychiatric facilities, if covered under the plan.

VERIFICATION: Court records, birth certificate, agency records

CITATION: 42CFR435.222, 45CFR233.110

E. STATE PLAN NOT AS BROAD AS ALLOWED UNDER TITLE IV-A

DEFINITION: (a) The agency may provide Medicaid to individuals who (1) would be eligible for AFDC if the State's AFDC plan included individuals whose coverage under title IV-A is optional (for example, Medicaid may be provided to members of families with unemployed parent even though AFDC is not available to them under the State's AFDC plan); or (2) would be eligible for AFDC if the State's AFDC plan did not contain eligibility requirements more restrictive than, or in addition to, those required under title IV-A. (b) The agency may cover any AFDC optional group without covering all such groups.

VERIFICATION: Case record

CITATION: 42CFR435.223

F. OPTIONAL STATE SUPPLEMENT RECIPIENTS (Cont)

DEFINITION: Payment under the Supplemental program must be equal to the difference between the individuals countable income and the income standard used to determine eligibility for supplementation.

State Supplement payments must be available to all individuals in the State.

VERIFICATION: Case record

CITATION: 42CFR435.230

G. INDIVIDUALS IN INSTITUTIONS WHO WOULD NOT BE ELIGIBLE FOR CASH ASSISTANCE IF THEY WERE NOT INSTITUTIONALIZED

DEFINITION: If an agency covers individuals who would be eligible for cash assistance except for their institutional status, it may also cover, individuals who would not be eligible for cash assistance if they were not institutionalized. May cover aged, blind, and disabled individuals in institutions if:

(a) their income makes them ineligible for SSI or State Supplement, but

(b) income is below a level specified in the State plan under 42CFR435.722.

These individuals may be covered even if there is no State Supplementation.

VERIFICATION: Case record

CITATION: 42CFR435.231

H. RECIPIENTS OF HOME AND COMMUNITY-BASED SERVICES WHO ARE ELIGIBLE UNDER SPECIAL INCOME LEVEL

DEFINITION: If the agency provides Medicaid to individuals in institutions who are eligible under a special income level, it may also cover aged, blind and disabled individuals who, because of their income, are not eligible for SSI or State supplements and have income below the standards established for institutionalized individuals, but will receive home and community based services under a waiver.

VERIFICATION: State plan, worker report, local office record

CITATION: 42CFR435.231

I. MEDICALLY NEEDY AFDC

DEFINITION: If the State has a medically needy program, the State must provide Medicaid to:

(a) All pregnant women during the course of their pregnancy who, but for income and resources, would be eligible for Medicaid as categorically needed.

(b) All individuals under age 21 (or, at State option, under age 20, 19, or 18 as elected for the State's categorically needy group) who meet the income and resource standards for the medically needy. The agency may cover all individuals or reasonable classifications of those individuals.

VERIFICATION: State plan, State and county records

CITATION: 42CFR435.301, 42CFR435.310

J. CARETAKER RELATIVE

DEFINITION: The agency may provide Medicaid to caretaker relatives who have an individual in their care determined to be a dependent child.

VERIFICATION: Case record

CITATION: 42CFR435.310, 45CFR233.90(c)(1)(v)(A)

K. MEDICALLY NEEDY AGED, BLIND AND DISABLED

DEFINITION: (a) Medicaid coverage in States that cover individuals receiving SSI may be provided to individuals defined as aged or blind or disabled (or any combination) who meet the income and resource requirements for the medically needy. (b) Medicaid coverage in States that impose eligibility requirements more restrictive than used under SSI may be provided to individuals defined as aged or blind or disabled (or any combination) who meet the income and resource standards established for the State and, if applying as blind or disabled, meet the blindness and disability requirements established under 435.121.

VERIFICATION: State plan

CITATION: 42CFR435.320, 42CFR435.322, 42CFR435.324, 42CFR435.330

L. MEDICALLY NEEDY BLIND AND DISABLED INDIVIDUALS ELIGIBLE IN 12/73

DEFINITION: If an agency provides Medicaid to the medically needy, coverage must be provided to individuals who (a) were eligible as medically needy under the Medicaid plan in December 1973 on the basis of the blindness or disability criteria of the AB, APTD, or AABD plan; (b) for each consecutive month after December 1973, continue to meet (1) those blindness or disability criteria; and (2) the eligibility requirements for the medically needy under the 12/73 Medicaid plan: and (c) meet the current requirements for eligibility as medically needy under the Medicaid plan except for blindness or disability criteria.

VERIFICATION: State plan

CITATION: 42CFR435.340

15340. FINANCIAL DATA REQUIREMENTS

15341. GENERAL

A. APPLICATION(S) FOR OTHER BENEFITS

DEFINITION: Agency must require applicants and recipients to take all necessary steps to obtain any annuities, pensions, retirement and disability benefits to which they are entitled, unless they can show good cause for not doing so.

VERIFICATION: Applicant's statement, notices from other agencies

CITATION: 42CFR435.603

CROSS REFERENCE: 1.21, 3.20 - 3.22

B. GENERAL FINANCIAL REQUIREMENTS FOR CATEGORICALLY NEEDY (FAMILIES & CHILDREN)

DEFINITION: Medicaid agency must apply the financial eligibility requirements of the States' AFDC plan.

VERIFICATION: State plan

CITATION: 42CFR435.711

CROSS REFERENCE: 2.01 - 2.11, 3.01 - 3.60

C. FINANCIAL RESPONSIBILITY OF SPOUSES AND PARENTS FOR FAMILIES AND CHILDREN

DEFINITION: (1) The agency must consider income and resources of spouses or parents as available to the individual or each other whether or not they actually contributed, if in the same household. (2) If the parent/spouse does not live with the individual, the agency must consider only income and resources that are actually contributed to the individual from a parent or spouse. (3) The agency must consider parental income and resources as available to a child if he is living with the parent until he is 21.

VERIFICATION: Pay stubs and/or authorized information from employer, tax returns, letters of entitlement

CITATION: 42CFR435.712

CROSS REFERENCE: 1.01, 1.06, 1.07, 1.10, 1.25, 2.02, 2.03, 2.05 - 2.11, 3.01, 3.22 - 3.60

D. FINANCIAL RESPONSIBILITY OF SPOUSES - AGED, BLIND, AND DISABLED IN STATES COVERING INDIVIDUALS RECEIVING SSI

DEFINITION: (1) The agency must consider income and resources of spouses living in the same household as available to each other, whether or not they are actually contributed.

(2) If both spouses apply or are eligible as aged, blind or disabled and cease to live together, the agency must consider their income and resources as available to each other for the first 6 months after the month they cease to live together.

(3) If only one spouse is eligible and they cease to live together, the agency must consider only the income and resources of the ineligible spouse that are actually contributed to the eligible spouse after the month in which they cease to live together.

VERIFICATION: Pay stubs and/or authorized information from employers, tax returns, letters of entitlement.

CITATION: 42CFR435.723

CROSS REFERENCE: 1.06, 1.07, 1.10, 1.25, 2.03, 2.05-2.07, 3.60

E. FINANCIAL ELIGIBILITY REQUIREMENTS FOR OPTIONAL GROUPS IN STATES USING SSI STANDARDS

DEFINITION: This section applies when an agency provides Medicaid to all SSI recipients and/or State supplement recipients, and the optional coverage groups specified in 435.210, 435.211, 435.231. (1) If the agency provides Medicaid to SSI recipients but not to State supplement recipients, it must use the SSI financial

E. FINANCIAL ELIGIBILITY REQUIREMENTS FOR OPTIONAL GROUPS IN STATES USING SSI STANDARDS (Cont.)

DEFINITION (Cont.): eligibility requirements to determine eligibility for the aged, blind, disabled individuals under the optional provisions of 435.210, 435.211, and 435.231; however, under the 435.231 it may use a higher income standard than SSI to determine eligibility for institutionalized individuals. (2) If the agency provides Medicaid to SSI recipients and under 435.230 recipients of optional State supplement, the agency must use the following criteria to determine eligibility under the optional provisions of 435.210, 435.211 and 435.231. (a) The agency must use the SSI financial requirements for individuals who would be eligible for SSI, but not optional State supplement. (b) The agency must use the supplement program's financial eligibility requirements for individuals who would be eligible for an optional State supplement. However, the agency may use a higher income standard than SSI or the State supplement program to determine eligibility of institutionalized individuals under 435.231. (c) The agency must use the SSI deductions from income and resources and budgeting set forth in 20 CFR Part 416, unless greater deductions from income and higher income standards are used in an optional State supplement program that meets the requirements of 435.230.

VERIFICATION: State plan and SDX record

CITATION: 42CFR435.721

CROSS REFERENCE: 2.31, 2.41, 3.01, 3.22 - 3.60

F. INSTITUTIONALIZED INDIVIDUALS WHO WOULD NOT BE ELIGIBLE FOR CASH IF THEY WERE NOT INSTITUTIONALIZED

DEFINITION: The agency must use income standards based on the greater need for financial assistance that the individual would have if they were not institutionalized. Income standards must be applied the first full month of institutionalization. Gross income standards may not exceed 300% of the SSI benefit amount payment.

VERIFICATION: State plan

CITATION: 42CFR435.722, 42CFR435.1005

CROSS REFERENCE: 1.10 - 1.12, 3.01, 3.22, 3.60

G. RESPONSIBILITY OF PARENTS FOR BLIND, DISABLED CHILDREN IN STATES COVERING INDIVIDUALS RECEIVING SSI

DEFINITION: If a child under 18 is living with parent or spouse of parent, the agency must consider the parent's or parental spouse's income and resources as available to the child, whether or not actually contributed. After the month in which the child ceases to live with a parent or spouse of a parent, only income or resources actually contributed is considered.

VERIFICATION: Pay stubs and/or authorized information from employers, tax returns, letters of entitlement

CITATION: 42CFR435.724

CROSS REFERENCE: 1.02, 1.09-1.12, 1.25, 2.11, 3.01, 3.22, 3.60

H. APPLICATION OF PATIENT INCOME TO THE COST OF CARE

DEFINITION: The agency must reduce its payment to an institution for services provided to individuals in medical institutions and intermediate care facilities by the amount that remains after deducting from the individual's income (1) $25 a month for an aged, blind or disabled individual, (2) $50 a month for a couple if both spouses are aged, blind or disabled, (3) for other individuals, a reasonable amount set by the agency based on a reasonable difference in their personal needs from those of the aged, blind or disabled.

VERIFICATION: State plan

CITATION: 42CFR435.725, 42CFR435.733

CROSS REFERENCE: 1.10-1.12, 3.01, 3.22, 3.60

I. FINANCIAL RESPONSIBILITY OF SPOUSES AND PARENTS IN 209(b) STATES (SECTION 1902(f) OF THE ACT)

DEFINITION: In determining Medicaid eligibility of an aged, blind, or a disabled individual under requirements more restrictive than those used under SSI, the agency must consider the income and resources of spouses and parents as available to the individual in the manner specified in 435.723 and 435.724 or in a more extensive manner, but not more extensive than the requirements in effect under the Medicaid plan on January 1, 1972. However, when either an individual or his spouse is institutionalized, the agency may consider the income of an individual as available to a spouse in one of the following ways:

(1) Use the SSI criteria for determining the amount and duration of availability of income,

(2) Use criteria more liberal than SSI criteria,

(3) May consider only income actually contributed when the spouses have ceased to live together.

I. FINANCIAL RESPONSIBILITY OF SPOUSES AND PARENTS IN 209(b) STATES (SECTION 1902(f) OF THE ACT) (Cont.)

VERIFICATION: State plan, pay stubs

CITATION: 42CFR435.734

CROSS REFERENCE: 1.02, 1.06, 1.09-1.12, 1.25, 2.02, 2.03, 2.05, 2.11, 3.01, 3.22, 3.60

J. PROTECTED MEDICAID ELIGIBILITY FOR INDIVIDUALS ELIGIBLE IN DECEMBER 1973

DEFINITION: In determining whether individuals continue to meet the income requirements used in December 1973, for purposes of determining eligibility under 435.131, 435.132, and 435.133, the agency must deduct increased OASDI payments to the same extent that these deductions were in effect in December 1973.

VERIFICATION: State or county case record

CITATION: 42CFR435.740

CROSS REFERENCE: 1.43, 2.31, 2.41, 3.22

K. DISPOSAL OF RESOURCES FOR LESS THAN FAIR MARKET VALUE

DEFINITION: Effective July 1,1981, an individual otherwise eligible for medical assistance under a State plan may be denied such assistance if the individual would not be eligible but for the fact that he/she disposed of nonexcludable resources for less than the fair market value within the preceeding 24 months, and the State plan provides for the denial of such assistance by reason of such disposal of resources. It shall be presumed that this transaction was for the purpose of establishing Medicaid eligibility unless convincing evidence is furnished to establish that the transaction was exclusively for some other purpose. The State plan shall specify a procedure for implementing the denial which is not more restrictive than 24 months unless the uncompensated value of the disposed resource exceeds $12,000. If over $12,000, the period of ineligibility may exceed 24 months but must bear a reasonable relationship to the uncompensated value.

An individual who resides in a State that elected to provide Medicaid to all SSI beneficiaries and who is ineligible for SSI solely because of the disposal of resources for less than the fair market value, may be eligible for Medicaid if the State plan did not require the inclusion of the disposed resource in the eligibility determination.

K. DISPOSAL OF RESOURCES FOR LESS THAN FAIR MARKET VALUE (Cont.)

VERIFICATION: Application form, bill of sale, deeds

CITATION: SSA 1902(j)

CROSS REFERENCE: 3.90 -3.93

15342. THIRD PARTY LIABILITY RESOURCES

A. HEALTH INSURANCE

DEFINITION: Any entity that is or may be liable to pay all or part of the medical, surgical, and/or hospital costs under a health insurance contract, plan or policy (whether issued to the beneficiary or to someone other than the beneficiary). The plan may be private, group, or governmental (includes Medicare and CHAMPUS).

VERIFICATION: Health insurance policy, Medicare card, card issued by employer or employer's insurance carrier

CITATION: 42CFR433.135

CROSS REFERENCE: 1.21, 2.03, 4.01-4.13, 7.01-7.05

B. CASUALTY INSURANCE

DEFINITION: Related to medical insurance due to accidental injury or illness at the hands of another.

Casualty resources may include auto insurance, Workmen's Compensation, commercial homeowner's liability policies, etc.

VERIFICATION: Court order and/or papers, Workmen's Compensation papers

CITATION: 1902(a)(25)

CROSS REFERENCE: 4.20-4.33

C. STATEMENT OF RELEASE OF MEDICAL INFORMATION

DEFINITION: For purposes of conforming to the Privacy Act, a statement of release of medical information must be in file.

VERIFICATION: Signature obtained during application process

CITATION: 42CFR433.135

CROSS REFERENCE: 4.14, 4.34

D. AUTHORIZATION TO ACT ON BEHALF OF BENEFICIARY IN FILE

DEFINITION: Assignment of benefits must be completed by the aid recipient in order to pursue the third party.

VERIFICATION: Signature obtained during application process.

CITATION: 42CFR433.146

CROSS REFERENCE: 4.15, 4.35

E. AFDC - ASSIGNMENT OF MEDICAL SUPPORT OBLIGATION FOR IV-D

DEFINITION: Legal authorization for the State to pursue medical care support and/or care payments on behalf of deprived child(ren).

VERIFICATION: N/A

CITATION: 45CFR232.11

CROSS REFERENCE: 7.01-7.05

15343. INCOME DISREGARDS

A. AFDC

DEFINITION: All of the earned income of each dependent child on AFDC who is: (a) a full-time student, or (b) a part-time student, who is not a full-time employee, attending a school, college or university or a course of vocational or technical training designed to fit him for gainful employment shall be disregarded.

Before disregarding student income and income set aside for future needs of a dependent child, not more than $750 per month of any income may be disregarded.

The first $75.00 of income of any child or relative or any other individual whose needs are taken into account in making the determination.

An amount equal to expenditures for care for each dependent child or incapacitated individual in the home, but not to exceed $160.00 per individual.

Any grant or loan to any undergraduate student for educational purposes made or insured under any programs administered by the Secretary of Education is excluded.

Loans and grants, such as scholarships that are not used for current living costs are excluded.

Income equal to expenses attributed to the earning of income (including earnings from public service employment) is excluded.

A. AFDC (Cont.)

DEFINITION (Cont.): For individuals found otherwise eligible to receive assistance or who have received assistance in one of the 4 months prior to the month of application, where appropriate, the State must also disregard from the individual's earned income $30 plus one-third of his earned income not already disregarded. However, the State may not provide the disregard to an individual after the fourth consecutive month it has been applied to his earned income unless he is not a recipient of aid for 12 consecutive months.

VERIFICATION: N/A

CITATION:
45CFR233.20(a)(11)(ii)(a), 45CFR233.20(a)(4)(i),
45CFR233.20(a)(3)(E)(iii), 45CFR233.20(a)(11)(b)(ii), 45CFR233.20(a)(4)(ii)(d),
45CFR233.20(a)(3)(E)(iv), 45CFR233.20(11)(V)(c), 45CFR233.20(11)(b),
45CFR233.20(11)(b)(2)

CROSS REFERENCE: 1.09, 5.00

B. SSI

DEFINITION: Payments or benefits provided under a Federal statute, other than title XVI of the Social Security Act, where exclusion is required by such statute;

Return or refund by any public agency of taxes on real property or food;

Assistance based on need which is paid by any State or political subdivision in supplementation of benefits;

Tuition and fee portions of grants, scholarships and fellowships;

Home produce used for personal consumption;

Infrequently or irregularly received income, unearned and earned, if such income does not exceed $20 per month of unearned income and $10 per month of earned income;

Certain payments received for foster care;

One third of child support payments by an absent parent;

Student child's earned income up to specific limits;

The first $20 per month of income, earned or unearned, other than income based on need;

Earned income in the amount of $65 plus one half of the remainder of the earned income per month;

Work expenses of the blind;

B. SSI (Cont.)

DEFINITION: Income of the blind and disabled needed to fulfill an approved plan for the achievement of self support; (In determining the countable income, the exclusions listed shall apply first to unearned income, and then to earned income, where appropriate. In so applying they shall be considered in the numerical sequence in which they are listed.)

Income exclusions for certain blind individuals:

(a) For an individual (or individual and spouse) who is blind as defined under a State plan in effect in October 1972, which was approved under title X or XVI of the Act, and who, for the month of December 1973, was a recipient of aid or assistance, the maximum amount of any earned or unearned income which could have been disregarded under such State plan will be disregarded in determining countable income in lieu of applying the exclusions from income set forth above, if application of the provisions above would result in a larger amount of countable income, provided that such individual (or individual and spouse, as the case may be):

(1) Has, since December 1973, resided continuously in the State under whose plan he was eligible for the month of December 1973; and

(2) Has not, since December 1973, been ineligible for a period exceeding 6 consecutive months for a supplemental security income benefit.

(b) For purposes of this section, an individual will cease to reside continuously in a State if he leaves the State with the present intention to abandon his home there.

VERIFICATION: N/A

CITATION: 20CFR416.1145(a), 20CFR416.1145(b)(1), 20CFR416.1145(b)(2), 20CFR416.1145(b)(3), 20CFR416.1145(b)(4), 20CFR416.1145(b)(5), 20CFR416.1145(b)(6), 20CFR416.1145(b)(7), 20CFR416.1145(b)(8), 20CFR416.1145(b)(9), 20CFR416.1145(b)(10), 20CFR415.1145(b)(11), 20CFR416.1145(b)(12), 20CFR416.1175(a)(b)

CROSS REFERENCE: 3.22, 5.00

C. SSI AND AFDC

DEFINITION: The value of a family's monthly allotment of food stamps and any rent or housing subsidy may be excluded (optional).

The value of USDA donated foods (surplus commodities) is excluded.

Any payment received under title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 is excluded.

C. SSI AND AFDC (Cont.)

DEFINITION: Any funds distributed per capita to, or held in trust for, members of any Indian tribe under P.L. 92-254 or P.L. 93-134;

Any benefits received under title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965, as amended;

Payments for supporting services or reimbursement of out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and any other programs under titles II and III, pursuant to section 418 of P.L. 93-113;

Payments to volunteers under title I (VISTA) of P.L. 83-113, pursuant to section 404(g) of P.L. 93-113;

The value of supplemental food assistance received under the Child Nutrition Act of 1966 as amended, and the special food service program for children under the National School Lunch Act, as amended (P.L. 92-433 and P.L. 93-150);

The weekly incentive allowance made under Section 111 of P.L. 93-203, the Comprehensive Employment and Training Act of 1973;

Tax-exempt portions of payments made pursuant to P.L. 92-203, the Alaska Native Claims Settlement Act;

Judgment payments to members of the Blackfeet and Gros Ventre Tribes of Indians under the provisions of P.L. 92-254;

Experimental Housing Allowance Program payments under Annual Contributions contracts entered into prior to January 1, 1975, under Section 23 of U.S. Housing Act of 1937.

VERIFICATION: N/A

CITATION: 45CFR233.20(a)(4)(ii)(a), 45CFR233.20(a)(4)(ii)(b), 45CFR233.20(a)(4)(ii)(c), 45CFR233.20(a)(4)(ii)(e), 45CFR233.20(a)(4)(ii)(f), 45CFR233.20(a)(4)(ii)(g), 45CFR233.20(a)(4)(ii)(h), 45CFR233.20(a)(4)(ii)(i), 45CFR233.20(a)(4)(ii)(j), 45CFR233.20(a)(4)(ii)(k), 45CFR233.20(a)(4)(ii)(m), 45CFR233.20(a)(4)(ii)(l)

CROSS REFERENCE: 3.22, 5.00

D. MEDICALLY NEEDY ONLY

DEFINITION: For individuals under age 21 and caretaker relatives, the income that would be deducted in determining eligibility under the State's AFDC plan.

D. MEDICALLY NEEDY ONLY (Cont.)

DEFINITION: NOTE: The disregard of the first $30 plus one third of the remainder of earned income is applied only in computing the amount of an AFDC payment (i.e., not in determining eligibility for AFDC) and is thus not applicable to the medically needy, unless the individual had received assistance in one of the 4 months prior to the month of application (see 15343A).

For aged, blind, and disabled individuals and couples the highest of the disregards allowed in determining financial eligibility for SSI benefits or for State supplementary payments (which are available to all eligible aged, blind and disabled individuals in the State) are deducted.

However, States which exercise their option under SSA-1902(f) of the Social Security Act to limit Medicaid coverage of categorically needy aged, blind, and disabled individuals to those who can meet more restrictive eligibility criteria for Medicaid than for receipt of SSI benefits, may allow disregards which are: (a) more restrictive than that allowed under the SSI or State supplementary payment program, but (b) no more restrictive than that allowed under the January 1972 medical assistance plan nor than those allowed under the current medical assistance plan for the aged, blind, and disabled categorically needy.

VERIFICATION: N/A

CITATION: 42CFR435.831(a)(1),(2), and (3)

CROSS REFERENCE: 3.22, 5.00

E. SSI, AFDC AND MEDICALLY NEEDY ONLY (DEEMED)

DEFINITION: The amount of the 20 percent increase in title II benefits resulting from enactment of P.L. 92-336 will be disregarded in determining Medicaid eligibility of any individual who (a) for August 1972, was receiving or eligible for cash assistance under title I, IV-A, X, XIV, or XVI of the Act, (b) for August 1972, was entitled to monthly insurance benefits under title II of the Act; and (c) except for the amount of the 20 percent increase in title II benefits; would currently be eligible for cash assistance (includes persons eligible for cash assistance if they applied or if they were not residing in a title XIX facility, where such coverage is provided under the State plan).

If the amount of title II cost-of-living increase(s) after April 1977 was the sole cause of termination of SSI benefits for an individual, the State must continue to provide Medicaid to the individual.

VERIFICATION: N/A

CITATION: 42CFR435.114 and 435.134, 42CFR435.135

CROSS REFERENCE: 5.00

15344. SPENDDOWN (SHARE OF COST)

A. MEDICALLY NEEDY INCOME LEVEL (MNIL)

DEFINITION: The income standard established for a State to determine the eligibility of medically needy individuals and families. If countable income (see below) is equal to or less than the applicable income standard, the individual or family is eligible for Medicaid.

The agency must use an income standard that is (1) based on family size, (2) uniform for all individuals in a covered group, (3) not in excess of 133 1/3 percent of the highest money payment that would be made to an individual or a family of comparable size and (4) reasonable (as defined in 42CFR435.812).

The State plan must specify the income standard for each covered medically needy group. If the income standard is not presumed reasonable under 435.812, the State plan must describe that standard.

VERIFICATION: State plan

CITATION: 42CFR435.811, 42CFR435.812, 42CFR435.814

CROSS REFERENCE: 6.01

B. MAXIMUM MEDICALLY NEEDY INCOME LEVEL

DEFINITION: The income standard established for a State above which FFP is not available for services provided to medically needy recipients. For individuals, their annual income after deductions cannot exceed 133-1/3% of an amount reasonably related to the highest money payment ordinarily made under the State's AFDC plan to a family of two without income and resources; for couples and families of two or more, 133-1/3% of the highest money payment under AFDC to a family of the same size without income and resources.

VERIFICATION: N/A

CITATION: 42CFR435.1007

CROSS REFERENCE: 6.01

C. AVAILABLE INCOME

DEFINITION: The earned and unearned income used in determining the financial eligibility of a medically needy individual.

VERIFICATION: N/A

CITATION: 42CFR435.831

CROSS REFERENCE: 3.01, 3.22

D. APPLICABLE DISREGARDS

DEFINITION: Amounts that would be deducted in determining eligibility under AFDC for families and under SSI for aged, blind and disabled recipients.

VERIFICATION: N/A

CITATION: 42CFR435.831

CROSS REFERENCE: 5.00

E. COUNTABLE INCOME

DEFINITION: For the medically needy, countable income is determined by deducting the following amounts from income:

(1) for individuals under age 21 and caretaker relatives the agency must deduct amounts that would be deducted in determining eligibility under the State's AFDC plan.

(2) For aged, blind, or disabled individuals in States covering all SSI recipients, the agency must deduct amounts that would be deducted in determining eligibility under SSI. However, the agency must also deduct the highest amount from income that would be deducted in determining eligibility for optional State supplements if these supplements are paid to all individuals who are receiving SSI or would be eligible for SSI except for their income.

In States using more restrictive requirements for Medicaid than the SSI requirements, countable income is determined by deducting from income, (1) any SSI benefits, (2) any optional State supplement, and (3) other deductions from income applied under the Medicaid plan.

The treatment of income must be uniform for all individuals in a covered group and must be reasonable.

This figure is measured against the income level for Medicaid eligibility.

VERIFICATION: N/A

CITATION: 42CFR435.831(a), 42CFR435.732(a), 42CFR435.850

CROSS REFERENCE: 6.03

F. EXCESS COUNTABLE INCOME

DEFINITION: Amount of income to be applied toward incurred medical expenses. Subtract the MNIL from the countable income to obtain excess countable income figures.

F. EXCESS COUNTABLE INCOME (Cont.)

VERIFICATION N/A

CITATION: 42CFR435.831

CROSS REFERENCE: 6.01, 6.03

G. INCURRED MEDICAL EXPENSES

DEFINITION: Those expenses, not subject to third party liability (TPL), to be deducted from countable income if income exceeds the income standard (MNIL). The agency may set reasonable limits on the amounts of incurred medical expenses to be deducted from income. Noncovered services must be deducted before deducting covered services.

VERIFICATION: N/A

CITATION: 42CFR435.831(c)(1)(2)

CROSS REFERENCE: 6.04

H. SERVICE DATES

DEFINITION: Dates of incurred medical expenses.

VERIFICATION: N/A

CITATION: 42CFR831

CROSS REFERENCE: 6.04

I. MEDICARE, HEALTH INSURANCE PREMIUM DEDUCTIBLES AND COINSURANCE

DEFINITION: These expenses are to be deducted from countable income if countable income exceeds the income standard (MNIL).

VERIFICATION: N/A

CITATION: 42CFR435.831(c)(1)

CROSS REFERENCE: 6.04

J. MEDICALLY NEEDY STATE RESOURCE LEVEL

DEFINITION: The State must use a resource standard that is (1) based on family size, (2) uniform for all individuals in a group, and (3) reasonable (as defined in 42CFR435.841).

The State plan must specify the resource standard for each covered medically needy group. If the resource standard is not presumed to be reasonable under 435.841, the State plan must describe that standard.

VERIFICATION: State plan

CITATION: 42CFR435.840, 42CFR435.841, 42CFR435.843

CROSS REFERENCE: 6.05

K. NONEXCLUDABLE RESOURCES

DEFINITION: The value of an individual's or family's resources after deducting the value of resources that would be deducted in determining eligibility under SSI or the AFDC plan as applicable.

The treatment of resources must be uniform for all individuals in a covered group and must be reasonable.

VERIFICATION: N/A

CITATION: 42CFR435.845

CROSS REFERENCE: 3.60, 6.05

DATA ELEMENT DICTIONARY

CHAPTER 4

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15400. GENERAL

The Data Element Dictionary defines the individual data elements in numerical order. Some entries have been made in the "Remarks" field for clarification. The "Acceptable Synonyms and Abbreviations," the "Date" and usually the "Code Explanation" fields have been left blank for possible use by State system designers.

"Date" signifies the date of last change of any information concerning the data element. The "Cross Reference" field refers to the data requirements located in Chapter III. "Values" refers to the type of information to be collected to establish the data element and is not all inclusive. "Values" may be expanded or contracted to satisfy State program needs.

An entry of "Required" in the "Automation" field indicates this data must be computerized if the State plans to receive enhanced Federal funding for the system. "Optional" indicates automation is suggested but is not imperative to qualify for enhanced Federal funding. Certain data elements refer only to optional State medical services. An entry of "Required" on an optional data element applies only to those States offering the optional coverage to its Medicaid recipients.

"Code Explanation" refers to system programming codes which the State may wish to use. No codes are used in this Data Element Dictionary as the coding must be determined by the individual States. Only Elements 1.05 and 3.01 have entries in this field. 1.05 shows the racial and ethnic origins required by the Office of Management and Budget. 3.01 shows the types of earned income specified by regulations.

All data elements contained in this dictionary must be explicit or derivable from the data captured in the State systems. Allowances will only be made for those data elements applying to optional coverage in those States which do not provide optional coverage.

15410. DATA ELEMENT LISTING

1.01	Name
1.02	Date of Birth
1.03	Date of Death
1.04	Sex
1.05	Race or Ethnic Origin
1.06	Marital Status
1.07	Employment Status
1.08	Hours of Employment
1.09	Student Status
1.10	Living Arrangement
1.11	Date of Admission
1.12	Date of Discharge
1.20	Social Security Number
1.21	Health Insurance Claim Number
1.22	State Identification Number
1.23	Mailing Address
1.24	Resident Address
1.25	Relationship to Caretaker/Payee
1.26	Telephone Number
1.27	Pregnant
1.28	Pregnancy Medically Verified
1.29	Representative Payee
1.30	Citizenship
1.31	Date of U.S. Entry
1.32	Date State Residency Began
1.33	Date State Residency Ended
1.34	Permanent State Residency
1.35	Voluntary State Residency
1.36	Category
1.40	Initial Date of Contact
1.41	Application Date
1.42	Disposition Date
1.43	Eligibility Effective Date
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1.71	Notification Date to EPSDT Recipient
1.72	Recipient EPSDT Response Date
1.73	Recipient EPSDT Response
2.01	Reason for Deprivation
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2.03	Date Unemployment Began
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2.07	Work/Training Registration or Participation
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2.34	Initial Optical Examination or Reexamination Required
2.41	Disability
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3.01	Earned Income
3.20	Agreement to Obtain All Other Benefits
3.21	Is Good Cause Requirement Met for Failure to File for Other Benefits
3.22	Unearned Income
3.60	Resources
3.90	Fair Market Value of Disposed Resource
3.91	Amount Received for Disposed Resource
3.92	Date of Disposition of Resource
3.93	Presumption that Transfer of Assets for Eligibility Purposes Rebutted
4.01	Name of Recipient with Health Insurance Coverage
4.02	Type of Health Insurance
4.03	Name of Health Insurance Policy Holder
4.04	Address of Health Insurance Policy Holder
4.05	Relationship of Recipient to Health Insurance Policy Holder
4.06	Health Insurance Carrier Name
4.07	Health Insurance Carrier Address
4.08	Health Insurance Policy or Certificate Number
4.09	Health Insurance Group Name (If Applicable)
4.10	Health Insurance Group Address
4.11	Health Insurance Group Number
4.12	Start Date of Health Insurance Coverage
4.13	End Date of Health Insurance Coverage
4.14	Statement of Release of Medical Information in File (For HI Coverage)
4.15	Authorization to Act on Behalf of Health Insurance Beneficiary in File
4.20	Casualty Recipient Name
4.21	Name of Insured or Liable Party
4.22	Address of Insured or Liable Party
4.23	Type of Casualty Insurance
4.24	Casualty Insurance Carrier Name
4.25	Casualty Carrier Address
4.26	Casualty Policy or Claim Number
4.27	Date of Accident or Injury
4.28	Has Settlement Been Made
4.29	Restitution Been Received
4.30	Amount of Restitution

4.31 Legal Action Involved
4.32 Name of Attorney
4.33 Address of Attorney
4.34 Statement of Release of Medical Information in File (For Casualty Purposes)
4.35 Authorization to Act on Behalf of Beneficiary in File (For Casualty Purposes)

5.00 Income Disregards

6.01 Medically Needy Income Level (MNIL)
6.03 Countable Income Less MNIL
6.04 Incurred Medical Expenses
6.05 Resource Level

7.01 Absent Parent Address
7.02 Absent Parent Place of Employment
7.03 Absent Parent's Insurance Coverage
7.04 Assignment of Rights to Support in File
7.05 Evidence of Good Cause for Refusal to Cooperate

15420. INDIVIDUAL DATA ELEMENT DEFINITIONS

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.01

DATA ELEMENT NAME
Name

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
The individual under whose name the record is established.

CROSS REFERENCE
15310 A

REMARKS

VALUES
First Name
Middle Initial
Last Name

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.02

DATA ELEMENT NAME
Date of Birth

ACCEPTABLE SYNONYMS AND ABBREVIATIONS DATE

DEFINITION
Date individual was born

CROSS REFERENCE
15310 B

REMARKS

VALUES
Month
Day
Year

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.03

DATA ELEMENT NAME
Date of Death

ACCEPTABLE SYNONYMS AND ABBREVIATIONS DATE

DEFINITION
Date individual died

CROSS REFERENCE
15310 T

REMARKS

VALUES
Month
Day
Year

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.04

DATA ELEMENT NAME
Sex

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Gender designation of the individual

CROSS REFERENCE
15310 C

REMARKS
For identification of the individual, matching records, and statistical purposes

VALUES
Male
Female
Undetermined

AUTOMATION Required

CODE EXPLANATION

CODE **MEANING**

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.05

DATA ELEMENT NAME
Race or Ethnic Origin

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Indicates the individual's racial or ethnic origin

CROSS REFERENCE
15310 D

REMARKS

VALUES
Minimumly required are White, Black, Asian or Pacific Islander, Hispanic, American Indian/Alaskan Native or Unknown

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING
	White
	Black
	Asian or Pacific Islander
	Hispanic
	Am. Indian/Alaskan Native
	Unknown

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.06

DATA ELEMENT NAME
Marital Status

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Indicates the current marital status of the individual

CROSS REFERENCE
15310 E, 15341 C,H,I

REMARKS

VALUES
Married, Never Married, Divorced, Separated, Widowed

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.07

DATA ELEMENT NAME
Employment Status

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Current employment status of individual

CROSS REFERENCE
15310 F, 15341 C

REMARKS

VALUES
Employed, Unemployed, On Strike, Self-Employed, Not Applicable

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.08

DATA ELEMENT NAME
Hours of Employment

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Total weekly hours of employment

CROSS REFERENCE
15310 F
REMARKS

VALUES
Hours per week

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.09

DATA ELEMENT NAME
Student Status

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Current educational status

CROSS REFERENCE
15310 B, 15343 A

REMARKS

VALUES
Not Applicable, Full Time, Part Time

AUTOMATION Required

CODE	MEANING	CODE EXPLANATION

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.10

DATA ELEMENT NAME
Living Arrangement

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Type of housing arrangement for the applicant/recipient

CROSS REFERENCE
15310 K, 15341 C,E-H

REMARKS
The type of medical institution or intermediate care facility must be automated to determine income standard. Some examples are shown below.

VALUES
Private Household, Medical Treatment Facility, Residential Facility, Educational-Vocational Facility

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.11

DATA ELEMENT NAME
Date of Admission

ACCEPTABLE SYNONYMS AND ABBREVIATIONS DATE

DEFINITION
Beginning date of hospitalization or institutionalization

CROSS REFERENCE
15341 F,H

REMARKS
This is related to change of living arrangements, residency, and possible quality control use.

VALUES
Month
Day
Year

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.12

DATA ELEMENT NAME
Date of Discharge

ACCEPTABLE SYNONYMS AND ABBREVIATIONS DATE

DEFINITION
Ending date of hospitalization or institutionalization

CROSS REFERENCE
15341 F,H

REMARKS

VALUES
Month
Day
Year

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.20

DATA ELEMENT NAME
Social Security Number

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
A nine digit number assigned by the Social Security Administration for the reporting of income.

CROSS REFERENCE
15310 G

REMARKS

VALUES
Number

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.21

DATA ELEMENT NAME
Health Insurance Claim Number

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
A nine digit number plus an alpha suffix used for submission of SSA Medicare claims and for State Buy-In purposes; can also be 6 or 9 digits with 1-3 alpha prefixes for Railroad Retirement Board Medicare claims.

CROSS REFERENCE
15310 H, 15341 A

REMARKS

VALUES
Number from the SDX, BENDEX or Medicare card

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.22

DATA ELEMENT NAME
State Identification Number

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Unique number assigned by the State agency to identify an eligible individual

CROSS REFERENCE

REMARKS

VALUES
Number

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.23

DATA ELEMENT NAME
Mailing Address

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Mailing address for the delivery of notices and identification cards

CROSS REFERENCE
15310 I

REMARKS

VALUES
Number, Street,
Apt. or Room No.,
City, State, Zip Code

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.24

DATA ELEMENT NAME
Resident Address

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Place of residence of applicant

CROSS REFERENCE
15310 J

REMARKS
For personal contact; only required if different from mailing address

VALUES
Number, Street,
Apt. or Room No.,
City, County,
State, Zip Code

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.25

DATA ELEMENT NAME
Relationship to Caretaker/Payee

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Relationship of beneficiary to caretaker/payee

CROSS REFERENCE
15310 K, 15320 A, 15341 C,G

REMARKS

VALUES
Individual/Caretaker
Spouse
Child
Parent
Specified Relative

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.26

DATA ELEMENT NAME
Telephone Number

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Telephone number where individual may be reached

CROSS REFERENCE

REMARKS

VALUES
Area Code
Exchange
Number

AUTOMATION Optional

CODE EXPLANATION

CODE **MEANING**

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.27

DATA ELEMENT NAME
Pregnant

ACCEPTABLE SYNONYMS AND ABBREVIATIONS DATE

DEFINITION
This element indicates whether or not the individual is pregnant.

CROSS REFERENCE
15331 C

REMARKS

VALUES
Yes
No
Expected Delivery Date

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.28

DATA ELEMENT NAME

Pregnancy Medically Verified

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION

Pregnancy must be medically verified if State deems pregnant women to be receiving AFDC.

CROSS REFERENCE

15331 C

REMARKS

VALUES

Yes
No

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.29

DATA ELEMENT NAME
Representative Payee

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Person approved to receive notices and I.D. cards on behalf of beneficiary

CROSS REFERENCE
15310 P

REMARKS

VALUES
First Name
Middle Initial
Last Name

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.30

DATA ELEMENT NAME
Citizenship

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Indicates a native or naturalized citizen or alien lawfully admitted for permanent residence

CROSS REFERENCE
15310 L

REMARKS

VALUES
U.S. Citizen
Legally Admitted Alien
Refugee Admitted Under Color of Law
Other (must be Federally granted status, e.g. Cuban, Haitian entrants)

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

best copy available

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.31

DATA ELEMENT NAME
Date of U.S. Entry

ACCEPTABLE SYNONYMS AND ABBREVIATIONS DATE

DEFINITION
Date of applicant's most recent entry to the U.S. (for legal aliens) and those eligible for "Refugee Medical Assistance"

CROSS REFERENCE
15310 L

REMARKS

VALUES
Month
Day
Year

AUTOMATION Required

CODE EXPLANATION

CODE **MEANING**

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.32

DATA ELEMENT NAME
Date State Residency Began

ACCEPTABLE SYNONYMS AND ABBREVIATIONS DATE

DEFINITION
Date individual established residency within the State

CROSS REFERENCE
15310 M

REMARKS

VALUES
Month
Day
Year

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.33

DATA ELEMENT NAME
Date State Residency Ended

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Date individual terminated State residency

CROSS REFERENCE
15310 M,T

REMARKS

VALUES
Month
Day
Year

AUTOMATION Optional

CODE EXPLANATION

CODE **MEANING**

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.34

DATA ELEMENT NAME
Permanent State Residency

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
This element indicates whether an individual's intent is to remain in the State on a permanent basis.

CROSS REFERENCE
15310 M

REMARKS

VALUES
Yes
No

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.35

DATA ELEMENT NAME
Voluntary State Residency

ACCEPTABLE SYNONYMS AND ABBREVIATIONS DATE

DEFINITION
This element indicates whether the individual freely established permanent residency and the date this residency began.

CROSS REFERENCE
15310 M

REMARKS

VALUES
Month, Day, Year
Yes, No

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.36

DATA ELEMENT NAME
Category

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Applicant's category, or voluntary choice of program category if eligible under more than one category

CROSS REFERENCE
15310 N

REMARKS

VALUES
Aged, Blind, Disabled, AFDC, MAO, Adoptive or Foster Care (title IV-E)

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.40

DATA ELEMENT NAME
Initial Date of Contact

ACCEPTABLE SYNONYMS AND ABBREVIATIONS DATE

DEFINITION
Date of applicant's first contact with agency

CROSS REFERENCE
15310 O

REMARKS

VALUES
Month
Day
Year

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.41

DATA ELEMENT NAME
Application Date

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Date written application filed with agency

CROSS REFERENCE
15310 P

REMARKS

VALUES
Month
Day
Year

AUTOMATION Required

CODE EXPLANATION

CODE **MEANING**

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.42

DATA ELEMENT NAME
Disposition Date

ACCEPTABLE SYNONYMS AND ABBREVIATIONS DATE

DEFINITION
This element shows the date the agency mails the claimant its eligibility decision.

CROSS REFERENCE
15310 Q

REMARKS

VALUES
Month
Day
Year

AUTOMATION Required

CODE EXPLANATION

CODE **MEANING**

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.43

DATA ELEMENT NAME
Eligibility Effective Date

ACCEPTABLE SYNONYMS AND ABBREVIATIONS DATE

DEFINITION
The date the individual's coverage begins.

CROSS REFERENCE
15310 R

REMARKS

VALUES
Month
Day
Year

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.44

DATA ELEMENT NAME
Eligibility Termination Date

ACCEPTABLE SYNONYMS AND ABBREVIATIONS DATE

DEFINITION
The date the individual's coverage ends.

CROSS REFERENCE
15310 T

REMARKS

VALUES
Month
Day
Year

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.45

DATA ELEMENT NAME
Eligibility Redetermination Date

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Date eligibility must be redetermined

CROSS REFERENCE
15310 S

REMARKS

VALUES
Month
Day
Year

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.46

DATA ELEMENT NAME
SSN Verification

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Verification of previously unverified SSN or application for SSN at time of recertification

CROSS REFERENCE
15310 U

REMARKS

VALUES
Yes
No

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.47

DATA ELEMENT NAME
Authorization to Obtain Data

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Written permission from individual for agency to obtain information or verification from third parties

CROSS REFERENCE

REMARKS

VALUES
Yes
No

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.71

DATA ELEMENT NAME
Notification Date to EPSDT Recipient

ACCEPTABLE SYNONYMS AND ABBREVIATIONS DATE

DEFINITION
Date of notification of available EPSDT health services

CROSS REFERENCE
15310 V

REMARKS

VALUES
Month
Day
Year

AUTOMATION Required

CODE EXPLANATION

CODE **MEANING**

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.72

DATA ELEMENT NAME
Recipient EPSDT Response Date

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Date of recipient's answer to notification of available EPSDT health services

CROSS REFERENCE
15310 V

REMARKS

VALUES
Month
Day
Year

AUTOMATION Required

CODE EXPLANATION

CODE	**MEANING**

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 1.73

DATA ELEMENT NAME
Recipient EPSDT Response

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Acceptance or rejection of proferred EPSDT health care services

CROSS REFERENCE
15310 V

REMARKS

VALUES
Yes
No

AUTOMATION Required

CODE EXPLANATION

CODE **MEANING**

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 2.01

DATA ELEMENT NAME
Reason for Deprivation

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Reason that child is not in receipt of parental support or care

CROSS REFERENCE
15320 A, 15341 B

REMARKS

VALUES
Death of Parent, Absence of Parent, Incapacitated Parent, Unemployed Parent

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 2.02

DATA ELEMENT NAME
Date of Loss of Parental Support

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Date when parental deprivation began

CROSS REFERENCE
15320 A, 15341 B,C

REMARKS

VALUES
Month
Day
Year

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 2.03

DATA ELEMENT NAME
Date Unemployment Began

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Day parent's employment terminated

CROSS REFERENCE
15320 A, 15341 B,C, 15310 F

REMARKS

VALUES
Month
Day
Year

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 2.04

DATA ELEMENT NAME
"Good Cause" Condition Met for Refusing Employment

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Whether parent is able to justify reason for declining job offer (e.g., physical or transportation reasons)

CROSS REFERENCE
15310 F. 15320 A, 15341 B

REMARKS

VALUES
Yes
No

AUTOMATION Optional

CODE EXPLANATION

CODE **MEANING**

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 2.05

DATA ELEMENT NAME
Quarters of Employment

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Had 6 or more quarters of employment at $50.00 or more during any 13 quarter period ending 1 year prior to application.

CROSS REFERENCE
15320 A, 15341 B,C,D, 15310 F

REMARKS
This element establishes deprivation in a situation where a parent has become unemployed.

VALUES
Yes
No

AUTOMATION Optional

CODE EXPLANATION

CODE **MEANING**

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 2.06

DATA ELEMENT NAME
Hours of Employment per Month for Past 3 Months

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
The information determines whether a parent will be considered unemployed.

CROSS REFERENCE
15310 F, 15320 A, 15341 B,C,D

REMARKS

VALUES
Number

AUTOMATION Optional

CODE EXPLANATION

CODE	**MEANING**

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 2.07

DATA ELEMENT NAME
Work/Training Registration or Participation

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
WIN Program registration or at State option, employment under the Work Supplementation Program for an unemployed parent

CROSS REFERENCE
15310 F, 15320 A, 15341 B,C,D

REMARKS

VALUES
Yes
No

AUTOMATION Optional

CODE EXPLANATION

CODE **MEANING**

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 2.08

DATA ELEMENT NAME
Name of Absent Parent

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Name of parent not living with the child

CROSS REFERENCE
15320 A, 15341 C

REMARKS

VALUES
First Name
Middle Initial
Last Name

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 2.09

DATA ELEMENT NAME
SSN of Absent Parent

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
9 digit SSN of absent parent(s)

CROSS REFERENCE
15320 A, 15341 B,C

REMARKS

VALUES
Number

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 2.10

DATA ELEMENT NAME
Employment Status of Absent Parent

ACCEPTABLE SYNONYMS AND ABBREVIATIONS

DATE
5/10/82

DEFINITION
Whether the absent parent is employed

CROSS REFERENCE
15310 F, 15320 A, 15341 B,C

REMARKS
If employment is indicated this data will be useful for possible third party recovery.

VALUES
Employed
Not Employed
Unknown

AUTOMATION Optional

CODE EXPLANATION

CODE **MEANING**

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 2.11

DATA ELEMENT NAME
Child Living With Relative

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Whether a child is living with a relative specified by law in a place of residence maintained as his own home

CROSS REFERENCE
15320 A,K, 15341 B,C,G

REMARKS

VALUES
Yes
No

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 2.12

DATA ELEMENT NAME
Good Cause Absences from Home Which Do Not Violate Living With Requirements

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Absences from home which do not change the finding of "living with"

CROSS REFERENCE
15310 K, 15320 A

REMARKS

VALUES
Vacation
Hospital Care
Schooling

AUTOMATION Required

		CODE EXPLANATION
CODE	MEANING	

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 2.31

DATA ELEMENT NAME
Blindness

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION

Individual must meet State Plan requirement for blindness. State has option of:

1. SSI criteria, or
2. State definition of blindness under Medicaid Plan in effect on 01/01/72

Individuals eligible for Medicaid in 12/73 who continue to meet the State standard of blindness of 12/73 continue their eligibility.

CROSS REFERENCE
15320 C, 15331 H,N, 15332 K,L

REMARKS

VALUES
Yes
No

AUTOMATION Required

CODE EXPLANATION

CODE **MEANING**

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 2.34

DATA ELEMENT NAME
Initial Optical Examination or Reexamination Required

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
When an examination is required to determine whether eligibility is met or continues

CROSS REFERENCE
15320 C, 15331 N, 15332 K, L

REMARKS

VALUES
Month
Day
Year

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 2.41

DATA ELEMENT NAME

Disability

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION

Individual must meet State Plan requirement for disability. State has option of:

1. SSI criteria, or
2. State definition of disability under Medicaid Plan in effect on 01/01/72

Individuals eligible for Medicaid in 12/73 who continue to meet the State standard of disability of 12/73 continue their eligibility

CROSS REFERENCE

15320 D, 15331 H,I,N, 15332 K,L

REMARKS

VALUES

Yes
No

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 2.44

DATA ELEMENT NAME

Initial Medical Examination or Reexamination Required for disability

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION

When an examination is required to determine whether eligibility is met or continues for disability

CROSS REFERENCE

15320 D, 15332 K,L

REMARKS

VALUES

Month
Day
Year

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 3.01

DATA ELEMENT NAME
Earned Income

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Earned income is income in cash or in kind earned by an individual through the receipt of wages, salary, commissions, tips, or profits from self-employment including the earned income tax credit/advance.

CROSS REFERENCE
15341 B.I

REMARKS

VALUES
Amount, Employer's Name, Address, Frequency, Start Date, Stop Date, Reason for Terminations

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING
	Wages and Salary
	Tips over $20.00
	Commissions
	Self-Employment
	Earned Income Tax Credit

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 3.20

DATA ELEMENT NAME

Agreement To Obtain All Other Benefits

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION

An agreement to apply for other benefits to which entitlement may exist is a condition for eligibility.

CROSS REFERENCE

15341 A

REMARKS

VALUES

Yes
No

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 3.21

DATA ELEMENT NAME

Is Good Cause Requirement Met for Failure to File for Other Benefits

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION

Any failure to apply for other benefits to which entitlement may exist must be justified.

CROSS REFERENCE

15341 A

REMARKS

VALUES

Yes
No

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 3.22

DATA ELEMENT NAME
Unearned Income

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Unearned income is: SSI Benefits, Social Security Benefits, V.A. Benefits, V.A. Pension, Railroad Benefits, Civil Service, Military Allotments, Union Strike Benefits, Black Lung, Workmens Compensation, Unemployment Compensation, Private Pension, Alimony, Child Support, Money from Friends, Money from Relatives, Public Assistance, Rental Property, Room and Board Income, Training Incentive Payments, Scholarships, Prizes, Gifts, Awards, Interest, Dividends, Royalties, Annuities, In-Kind Income, Educational Loans, Inheritance, General Assistance, Income Tax Refunds, Life Insurance Payments, Value of Food Stamps, Value of Rent or Housing Subsidy, Others.

CROSS REFERENCE
15341 A,B,C, 15343 B,C,E

REMARKS
Unearned income must be identified by individual. Money amount (as a minimum) must be automated to allow a budget computation.

VALUES
Amount, Identification Number, Type, Frequency, Start Date, Stop Date, Source

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

Rev. 1

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 3.60

DATA ELEMENT NAME
Resources

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Real and personal property including liquid assets

CROSS REFERENCE
15341 B-I

REMARKS

VALUES
Current Cash Value, Type

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 3.90

DATA ELEMENT NAME
Fair Market Value of Disposed Resource

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
The fair market value of a resource owned by a claimant within the preceding 24 months of filing, if the resource was given away or sold at less than fair market value.

CROSS REFERENCE
15341 K

REMARKS

VALUES
Amount

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 3.91

DATA ELEMENT NAME
Amount Received for Disposed Resource

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
The compensation received for a resource given away or sold at less than fair market value. The value of the resource for computation purposes is the fair market value less the compensation received for the resource.

CROSS REFERENCE
15341 K

REMARKS

VALUES
Amount

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 3.92

DATA ELEMENT NAME
Date of Disposition of Resource

ACCEPTABLE SYNONYMS AND ABBREVIATIONS DATE

DEFINITION
The date of the disposal of the resource

CROSS REFERENCE
15341 K

REMARKS
Month
Year

VALUES

AUTOMATION Optional

CODE EXPLANATION

CODE **MEANING**

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 3.93

DATA ELEMENT NAME

Presumption that Transfer of Assets for Eligibility Purposes Rebutted

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION

The applicant may furnish convincing evidence that the transfer of assets was exclusively for some other purpose and not to establish eligibility for medical assistance.

CROSS REFERENCE

15341 K

REMARKS

VALUES

Yes
No

AUTOMATION Optional

CODE EXPLANATION

CODE **MEANING**

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.01

DATA ELEMENT NAME
Name of Recipient with Health Insurance Coverage

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Name of recipient with third party involvement

CROSS REFERENCE
15342 A

REMARKS
In a single case with multiple recipients, only one may have third party involvement. Therefore, it is necessary to identify each receipient.

VALUES
First Name
Middle Initial
Last Name

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.02

DATA ELEMENT NAME
Type of Health Insurance

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
The type of health insurance resource that exists for recipient, e.g., major medical, dental, vision, pharmacy or combinations.

CROSS REFERENCE
15342 A

REMARKS

VALUES
Type

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.03

DATA ELEMENT NAME
Name of Health Insurance Policy Holder

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Name of owner of the health insurance policy

CROSS REFERENCE
15342 A

REMARKS

VALUES
First Name
Middle Initial
Last Name

AUTOMATION Required

CODE EXPLANATION

CODE **MEANING**

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.04

DATA ELEMENT NAME
Address of Health Insurance Policy Holder

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Mailing address of policy owner

CROSS REFERENCE
15342 A

REMARKS

VALUES
Number, Street,
City, State, Zip Code

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.05

DATA ELEMENT NAME
Relationship of Recipient to Health Insurance Policy Holder

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Relationship by blood, marriage or other means of the recipient to the policy holder

CROSS REFERENCE
15342 A

REMARKS
The relationship determines why the recipient is entitled to third party coverage on the policy of another.

VALUES
Self, Spouse, Child, Mother, Father, Aunt, Uncle, Grandparent, Other

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.06

DATA ELEMENT NAME
Health Insurance Carrier Name

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Name of company which issued the policy

CROSS REFERENCE
15342 A

REMARKS

VALUES
Insurance Company Name

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.07

DATA ELEMENT NAME

Health Insurance Carrier Address

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION

Address to which medical bills should be submitted

CROSS REFERENCE

15342 A

REMARKS

VALUES

Number, Street,
City, State, Zip Code

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.08

DATA ELEMENT NAME

Health Insurance Policy or Certificate Number

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION

Identification number for third party coverage

CROSS REFERENCE

15342 A

REMARKS

VALUES

Number

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.09

DATA ELEMENT NAME
Health Insurance Group Name (if Applicable)

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Identifying title of group to whom the third party coverage policy is issued

CROSS REFERENCE
15342 A

REMARKS

VALUES
Name

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.10

DATA ELEMENT NAME
Health Insurance Group Address

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Mailing address of the group

CROSS REFERENCE
15342 A

REMARKS

VALUES
Number, Street,
City, State, Zip Code

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.11

DATA ELEMENT NAME
Health Insurance Group Number

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Identifying number of the group to whom the policy was issued

CROSS REFERENCE
15342 A

REMARKS

VALUES
Number

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.12

DATA ELEMENT NAME
Start Date of Health Insurance Coverage

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Date coverage begins

CROSS REFERENCE
15342 A

REMARKS

VALUES
Month
Year

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.13

DATA ELEMENT NAME
End Date of Health Insurance Coverage

ACCEPTABLE SYNONYMS AND ABBREVIATIONS DATE

DEFINITION
Date coverage stops

CROSS REFERENCE
15342 A

REMARKS

VALUES
Month
Year

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.14

DATA ELEMENT NAME
Statement of Release of Medical Information in File (for HI Coverage)

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Permission to release any medical information needed to pay a claim

CROSS REFERENCE
15342 C

REMARKS

VALUES
Yes
No

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.15

DATA ELEMENT NAME

Authorization to Act on Behalf of Health Insurance Beneficiary in File

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION

Permission for Medicaid to act on behalf of the recipient in soliciting payment from a third party

CROSS REFERENCE

15342 D

REMARKS

VALUES

Yes
No

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.20

DATA ELEMENT NAME
Casualty Recipient Name

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Name of recipient with third party casualty coverage

CROSS REFERENCE
15342 B

REMARKS

VALUES
First Name
Middle Initial
Last Name

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.21

DATA ELEMENT NAME
Name of Insured or Liable Party

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Name of owner of the casualty coverage

CROSS REFERENCE
15342 B

REMARKS

VALUES
First Name
Middle Initial
Last Name

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.22

DATA ELEMENT NAME
Address of Insured or Liable Party

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Mailing address of the owner of the casualty coverage

CROSS REFERENCE
15342 B

REMARKS

VALUES
Number, Street,
City, State, Zip Code

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.23

DATA ELEMENT NAME
Type of Casualty Insurance

ACCEPTABLE SYNONYMS AND ABBREVIATIONS DATE

DEFINITION
Kind of casualty coverage, e.g., auto, home

CROSS REFERENCE
15342 B

REMARKS

VALUES
Type

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.24

DATA ELEMENT NAME
Casualty Insurance Carrier Name

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Name of casualty insurance company

CROSS REFERENCE
15342 B

REMARKS

VALUES
Name

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.25

DATA ELEMENT NAME
Casualty Carrier Address

ACCEPTABLE SYNONYMS AND ABBREVIATIONS DATE

DEFINITION
Mailing address to which bills should be submitted

CROSS REFERENCE
15342 B

REMARKS

VALUES
Number, Street,
City, State, Zip Code

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.26

DATA ELEMENT NAME
Casualty Policy or Claim Number

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Identification number

CROSS REFERENCE
15342 B

REMARKS

VALUES
Number

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.27

DATA ELEMENT NAME
Date of Accident or Injury

ACCEPTABLE SYNONYMS AND ABBREVIATIONS DATE

DEFINITION
Date injury incurred

CROSS REFERENCE
15342 B

REMARKS

VALUES
Month
Day
Year

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.28

DATA ELEMENT NAME
Has Settlement Been Made

ACCEPTABLE SYNONYMS AND ABBREVIATIONS DATE

DEFINITION
Whether final payment figure has been accepted

CROSS REFERENCE
15342 B

REMARKS

VALUES
Yes
No

AUTOMATION Optional

CODE	MEANING	CODE EXPLANATION

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.29

DATA ELEMENT NAME
Restitution Been Received

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Whether complete payment has been received

CROSS REFERENCE
15342 B

REMARKS

VALUES
Yes
No

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.30

DATA ELEMENT NAME
Amount of Restitution

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Amount of settlement

CROSS REFERENCE
15342 B

REMARKS

VALUES
Amount

AUTOMATION Optional

CODE EXPLANATION

CODE **MEANING**

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.31

DATA ELEMENT NAME
Legal Action Involved

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Whether an attorney or court action is involved

CROSS REFERENCE
15342 B

REMARKS

VALUES
Yes
No

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.32

DATA ELEMENT NAME
Name of Attorney

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Attorney representing the Medicaid recipient

CROSS REFERENCE
15342 B

REMARKS

VALUES
First Name
Middle Initial
Last Name

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.33

DATA ELEMENT NAME
Address of Attorney

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Mailing address of representative attorney

CROSS REFERENCE
15342 B

REMARKS

VALUES
Number, Street,
City, State, Zip Code

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.34

DATA ELEMENT NAME

Statement of Release of Medical Information in File (for casualty purposes)

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION

Permission to release any medical information needed to settle the claim is included in the file

CROSS REFERENCE

15342 B

REMARKS

VALUES

Yes
No

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 4.35

DATA ELEMENT NAME
Authorization to Act on Behalf of Beneficiary in File (for casualty purposes)

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Permission for Medicaid to act on behalf of the recipient in settling the claim

CROSS REFERENCE
15342 D

REMARKS

VALUES
Yes
No

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 5.00

DATA ELEMENT NAME
Income Disregards

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
The absolute value or calculated amount to be deducted from earned or unearned income.

CROSS REFERENCE
15343 A-E, 15344 D

REMARKS

VALUES
Amount

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 6.01

DATA ELEMENT NAME
Medically Needy Income Level (MNIL)

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Income standard used in a jurisdiction to determine eligibility of Medically Needy individuals

CROSS REFERENCE
15344 A,B,F

REMARKS
Used by States with a Medically Needy program

VALUES
Amount

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

Rev. 1

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 6.03

DATA ELEMENT NAME
Countable Income Less MNIL

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Amount of income to be applied toward incurred medical expenses

CROSS REFERENCE
15344 E,F

REMARKS
Used by States with a Medically Needy program

VALUES
Amount

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 6.04

DATA ELEMENT NAME
Incurred Medical Expenses

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Those expenses not subject to TPL to be deducted from Medically Needy countable income.

CROSS REFERENCE
15344 G-I

REMARKS
Used by States with a Medically Needy program

VALUES
Amount of Medical Insurance Premiums, Amount of Deductibles, Amount of Coinsurance, Amount of Medical Charges, Month, Day, Year of Service Dates

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 6.05

DATA ELEMENT NAME
Resource Level

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Medically Needy resource standards established under a State's AFDC plan or SSI

CROSS REFERENCE
15344 J,K

REMARKS
Used only by States with a Medically Needy program

VALUES
Amount

AUTOMATION Required

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 7.01

DATA ELEMENT NAME
Absent Parent Address

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Mailing address of the non living with parent

CROSS REFERENCE
15341 C,G,I

REMARKS

VALUES
Number, Street,
City,
State,
Zip Code

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 7.02

DATA ELEMENT NAME
Absent Parent Place of Employment

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Name and mailing address of employer

CROSS REFERENCE
15341 C,G,I

REMARKS

VALUES
Number, Street,
City, State, Zip Code

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 7.03

DATA ELEMENT NAME
Absent Parent's Insurance Coverage

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Whether third party liability exists on the record of an absent parent

CROSS REFERENCE
15342 A,E

REMARKS

VALUES
Yes
No

AUTOMATION Required

CODE EXPLANATION

CODE **MEANING**

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 7.04

DATA ELEMENT NAME
Assignment of Rights to Support in File

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Whether the absent parent has agreed to support the recipient

CROSS REFERENCE
15341 C,G,I, 15342 E

REMARKS

VALUES
Yes
No

AUTOMATION Optional

CODE EXPLANATION

CODE	MEANING

MEDIRS
MEDICAID ELIGIBILITY DETERMINATION
AND
INFORMATION RETRIEVAL SYSTEM

DATA ELEMENT DEFINITION

DATA ELEMENT NUMBER 7.05

DATA ELEMENT NAME
Evidence of Good Cause for Refusal to Cooperate Indicator

ACCEPTABLE SYNONYMS AND ABBREVIATIONS **DATE**

DEFINITION
Whether good cause has been established when an absent parent does not cooperate in support

CROSS REFERENCE
15320 A, 15341 B

REMARKS

VALUES
Yes
No

AUTOMATION Optional

CODE EXPLANATION

CODE **MEANING**

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15500. GENERAL

State proposals for enhanced funding of Medicaid eligibility systems must conform to a set of basic system characteristics to qualify. APDs should be submitted in accordance with existing regulations. HCFA will use these criteria to measure whether a State APD complies with existing regulations. These criteria are for State guidance and use in APD preparation. The Federal evaluation criteria should be considered minimal standards rather than exclusive requirements, with States given leeway to accommodate local regulations, organization methods and unique situations. Some computerization and centralization will be required for approval. The system must automate those functions and elements requiring automation as indicated in Chapter II -Functional Requirements - and Chapter IV - Data Element Dictionary. Cost effectiveness of extensive computerization must be determined on an individual State basis.

A system proposal for Federal financial participation (FFP) must demonstrate economy, efficiency and effectiveness. It must also provide for security, an orderly conversion program, a timetable for action, budget and equipment specifications and adequate staff resources.

"APPROVAL CRITERIA FOR ADVANCE PLANNING DOCUMENTS FOR SYSTEMS, EQUIPMENT AND SERVICES" has been distributed by HHS. Although it continues as the general standard for APD evaluation, it does not specifically address Medicaid eligibility. The "MEDICAID ELIGIBILITY SYSTEM EVALUATION CRITERIA" incorporates the "APPROVAL CRITERIA FOR ADVANCE PLANNING DOCUMENTS," and retains the format used by the "APPROVAL CRITERIA." Specific Medicaid related items to be featured in the APD are shown.

Title 45 CFR 95.605 defines an advance planning document (APD) as "a written plan of action to acquire the proposed ADP services or equipment. The APD must contain a statement of needs and objectives; a preliminary costs/benefits analysis; a personnel resource statement indicating availability of qualified and adequate staff including a project director to accomplish the project objectives; a detailed description of the nature and scope of the activities to be undertaken and the methods to be used to accomplish the project; a proposed activity schedule for the project; a proposed budget; and a statement indicating the period of time the State expects to use the ADP service or equipment."

The advance plan provides HCFA information on which to base a decision to approve FFP in a proposed acquisition of an ADP system, equipment or services. It should include sufficient information to demonstrate that the State has identified the problem that needs to be addressed and has planned adequately for its resolution. The plan should present the pertinent information in simple, straightforward language.

In general, HCFA will use the advance plan to determine: if the proposed plan meets statutory requirements; if the State has considered the implications of the proposed action upon the recipients of system benefits and the State organization administering the program; and if the State has considered all essential activities required to accomplish the project successfully and in a timely fashion.

HCFA will suspend approvals of APDs when the State fails to comply substantially with the criteria, requirements, or other undertakings prescribed by the approved advance automated data processing planning document.

States should submit plans sufficiently in advance of initiation to allow time for:

HCFA plan review,
communication with the State if HCFA determines that plan changes are needed, and
finalization of the funding approval decision.

While HCFA's review process calls for an approval decision or status report to a State within 30 days of HCFA's receipt of the request, it is recommended that States submit advance plans at least 90 days prior to plan initiation. States' early submittal of advance plans will notify HCFA of States' intentions in the initial planning stages. This will permit time for HCFA communication and assistance to States in instances where plan deficiencies are noted or where HCFA has information on activities similar to that proposed which would aid States in their planning.

HCFA review staff will use these criteria as a basic guide to evaluate plan content and as the basis for funding approval.

Because concepts, project scopes and approaches to solving specific problems vary significantly, HCFA recognizes that APDs for different activities will vary. Also, State requirements will influence the construction of the plan. The approval criteria are not intended to dictate plan format, but to reflect the basic elements of project planning that HCFA expects States to consider prior to project activity.

The criteria specify minimum information needed for review of complete or discrete components of systems, equipment acquisitions or services. When requesting approval of extensive, complex activities, States need to provide information on each aspect of the endeavor. However, HCFA recognizes that States will not always have the planning information HCFA needs to approve a system acquisition in its entirety. In such instances, HCFA will approve only the initial phases of the system development, reserving decisions on the remaining phases of the system until the State can provide all the required planning information. This chapter indicates the information required in an initial APD and indicates the information which may be submitted later. Such incremental, phased-in design, development and implementation approaches will likely be widespread. The APD should still indicate the expected final form of the mechanized eligibility system and provide related technical and financial details which justify the chosen approach. HCFA must be able to make an initial determination of the feasibility and practicality of the proposed program preliminary to the award of funds for early phases. Actual, specific results of early phase design, development and implementation is required by HCFA prior to approval of continuing phases, with documentation of proposed adjustments to the original plan. In situations where the determination of the final form is dependent upon the results of an initial phase, the expected possible alternatives should be indicated and justified. Actual supporting technical and financial details must be supplied when funding is requested for the chosen alternative.

Any request for funds must fully explain and justify the tasks to be performed, the resources to be allocated and the time allotted. The State must retain ownership to any software developed for its automated eligibility system and assign HCFA use rights for possible transfer to other States.

MEDIRS APDs should be submitted to the:

Assistant Secretary for Management and Budget
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201
ATTN: Division of State Systems
Room 542.F

Multiprogram system requests from States must clearly indicate the Social Security Act titles under which funding is requested and the estimated amount or percent of total amount that is requested for each title. The State should send three copies of the request for each operating division that must approve the request. The head of the State agency, or an agency employee designated in writing by the agency head as an official requestor, shall sign the request for FFP.

When incentive FFP is authorized, additional material must be submitted by the State in conformance with the requirements of exhibit 11275.1 of Part 11 of the State Medicaid Manual. The system must pass the HCFA certification review prior to approval for 75 percent FFP for operational funding.

15510. EVALUATION FACTORS - SYSTEMS

15510.1 System Need

A. The plan must state the requirement which the system or system modification is intended to satisfy, such as:

1. A new Federal/State statutory or regulatory requirement, or
2. Other requirement that necessitated the development of the advance plan.

B. The plan must include the current process description.

C. It must explain the problem to be solved, and the failures or weak links within the existing system.

It must demonstrate how the problems would be solved and the weak links eliminated or strengthened in the new system.

D. A State which chooses a stand-alone, Medicaid only system, rather than an integrated multiprogram eligibility system must justify its choice. An integrated multiprogram eligibility system would generally yield the greatest overall cost/benefit savings and the State's decision not to pursue an integrated multiprogram eligibility system must be explained.

E. The plan must meet the MEDIRS data requirements and functional requirements and the minimum levels of automation indicated in the Functional Requirements and Data Element Dictionary chapters.

15510.2 System Objective

A. The plan must explain what the system is supposed to do, and how it will support programmatic or administrative objectives of the HCFA funded program, e.g., new or improved service delivery, operational efficiency, programmatic or administrative accountability.

B. The plan must define the objectives in a complete, clear manner which will enable an examiner to determine when the objectives have been accomplished.

C. The objectives must constitute a solution to the whole problem.

D. The following objectives must be included:

1. Timely access to management data,
2. Currency of data,

3. Performance of the eligibility function with less effort than presently employed,

4. Increased accuracy,

5. The ability to process a high volume of actions in a timely manner,

6. Data exchange capability,

7. Rapid update of the system,

8. Reduced paperwork,

9. Flexible to user needs,

10. Dependability,

11. Automation of many time-consuming and error-prone clerical functions,

12. Security,

13. Economy, efficiency, effectiveness, and

14. Timely issuance of the Medicaid card.

15510.3 Nature and Scope of the System

A. The plan must identify program(s) covered and give sufficient detail to enable each program component to identify functions and/or services provided or supported.

B. It must be designed to permit adaptations or enhancements.

C. The basic design must incorporate sufficient flexibility to encompass small scale as well as large scale operations within a State in a cost effective manner that is not dependent upon the availability of expensive hardware in a small office.

D. Third party liability information must be collected from the recipient, preferably during the eligibility process, to support the MMIS. A satisfactory alternate State method of collecting the data could also meet this requirement.

E. It must be designed to alleviate user workload, not add to it, and must be open to relatively simple interpretation, comprehension and input by users.

F. It must be able to handle what it is designed to do.

G. Output, including automated notices and Medicaid cards, and input must be clearly described.

15510.4 Proposed Approach to System Development

A. The plan should provide a narrative description of the proposed approach to system development, including the following information:

1. Whether the proposed system will replace or make additions, deletions, or changes to an existing system.

2. Whether the proposed system is designed around existing functional organizations and existing procedures, or, if not, whether the plan provides for determining changes required in the organizational or procedural structure in a time frame consistent with the system development schedule.

3. Whether the functions of the proposed system are duplicated in another system(s) currently in operation in the State; and if so, does the plan provide for phasing out the duplicated functions or provide justification for the duplication.

4. Whether a phased approach to systems implementation will be used, i.e., bringing up certain key features of the system in a local district prior to full systems implementation. In some areas, the implementation of items such as on-line inquiry and immediate need card issuance could result in early significant savings and improve county acceptance of and adaptation to the new automated system.

B. The plan must meet all mandatory Federal, State and county requirements.

It must provide for the resolution of any processing variations among districts when a centralized State system is planned.

C. It must include performance criteria identifying the major products of the system, e.g., reports, files, response time, notices, Medicaid cards.

D. It should provide for strong user interface with systems planning and development staff.

15510.5 Alternative Considerations

A. The examination of alternative systems which might be appropriate must include any State, county or local systems already in operation that might be expanded to satisfy eligibility determination needs.

B. The plan must clearly provide the general outline and major elements of each alternative.

C. It should include sufficient system information to verify costs and time estimates of each alternative.

D. The plan must describe specifically the alternative selected.

E. The plan must explain why the proposed system was selected, and its advantages versus other means of satisfying the stated needs and objectives (e.g., if the proposed system is a new system, whether the State considered upgrading system(s) or transferring in another system).

NOTE: Distributed processing has demonstrated cost effectiveness in large systems development and implementation in some States. The plan should indicate that it was evaluated for use in the system design and whether it could be efficiently used.

15510.6 Proposed Activity Schedule

A. The plan must describe the major phases and related tasks to be performed, and provide major project milestones and target dates for phase and task completion.

B. The plan must have decision points subject to subsequent modification where the State examines results to date, and decides on continued development or termination.

C. The plan should allow time for review and approval of phased activities.

D. The plan must provide for contingency plans to assure the project will be accomplished within schedule and costs.

E. It must provide that the State will have progress reporting, planning, and schedule information on development, conversion and implementation.

F. The method for control of design/system changes during the design, development and implementation should be described.

15510.7 System Accountability

A. The plan should specify organizational responsibility for ensuring that the system performs properly and efficiently.

B. The plan must describe the project management structure.

C. The plan should name the State project director with functional title and telephone number.

D. A list of responsibilities assigned to the State and any separate contractors must be outlined.

E. The plan must indicate any unique or unusual authorizations required for the system development and implementation.

15510.8 Cost Analysis/Benefits Anticipated

A. The analysis must provide the estimated cost to develop and operate the new system.

B. The analysis should explain the quantifiable and/or intangible benefits related to each of the funding sources and should be related to the cost allocation plan, e.g., it should estimate anticipated savings if the system is intended to detect or control administrative or programmatic fraud or waste.

C. The analysis should indicate the expected useful life of the system in relation to stated needs.

D. An economical system should be cost effective in comparison with the current system as indicated in a cost/benefit analysis.

E. There should be an improved ability to reduce error rates and to reduce program costs.

F. The system must handle required computations and calculations to encourage accuracy and to save time.

G. The cost/benefit analysis must identify the annual costs of the existing system.

H. A State must justify its cost allocation algorithm for an integrated eligibility system. The program/benefit formula the State has used and the basis of the formula must be shown. The cost allocation proposed by the State for an integrated multiprogram eligibility system will be compared with the cost allocation percentages approved by the DHHS Regional Office. Any State allocation varying from the DHHS RO percentage must be justified by the State before approval.

15510.9 Resource Statement

A. The plan must indicate that procurement activities will comply with Federal procurement regulations.

B. The task to be performed must justify the resources and time assigned to it.

15510.10 Budget

A. The plan must include a proposed budget.

B. The plan must provide a schedule of budgeted expenditures that corresponds with the activity schedule and resource statement.

C. The plan should explain that matching State funds are available for the system or describe how the State proposes to obtain State funds for the system.

15510.11 Cost Allocation

A. The plan should include or refer to a methodology for directly charging development and operational costs to the various funding sources.

B. The plan must explain the proposed methodology for distributing overhead costs that cannot be directly charged.

15520. EVALUATION FACTORS - EQUIPMENT

15520.1 Equipment Need

A. The plan should state, in narrative form, the requirement the equipment is to support, such as:

1. New software system for a program(s) not previously supported,
2. Redesigned system for a program(s) currently supported,
3. Growth in programs currently supported,
4. Improved operational efficiency, or
5. Replacement of equipment at lower cost.

B. The plan should state, when applicable, that the new or redesigned system the equipment is intended to support has been approved by HCFA, or that the State is requesting HCFA approval.

C. The plan should statistically project workload growth rate, by Medicaid funded systems areas, for the estimated period of time the existing, new or additional equipment is proposed for use.

D. The plan should explain the factors the statistical projection of workload requirements are based on, e.g., historical growth trend or expanded program coverage.

E. The plan should explain past or planned efficiency measures implemented to improve utilization of current equipment capacity, e.g., use of hardware or software monitors, off-loading program support systems or data management systems onto mini computers.

F. A totally or partially automated system must make the best use of its hardware, using existing technology and already owned equipment to the extent feasible.

G. The plan should indicate whether the existing hardware can handle the demands of the new system and the projected volume and whether the security protections of the existing equipment are adequate for the new system when new or additional hardware is not requested.

15520.2 Equipment Utilization

A. The plan should describe the utilization of current equipment capacity (by type of system component(s) being procured) for each Medicaid funded system area and non-Medicaid funded system area.

B. The plan should explain the method the State used to measure equipment utilization.

C. The plan should state:

1. The projected equipment capacity needed to support:

    a. each Medicaid funded system area, and
    b. each non-Medicaid funded service, and

2. The approximate period of time for which the projected capacity is considered sufficient.

15520.3 Resource Statement

A. The plan should describe the staff resource requirements and designate the person responsible for managing the acquisition.

B. Equipment staff must be justified by a dependable estimate of programming and traffic time.

15520.4 Cost

A. The plan should explain the proposed acquisition method, and its advantages over other alternatives, e.g., lease versus purchase.

B. The plan must include a methodology for directly charging acquisition and operational costs to the various funding sources.

C. The plan should explain the quantifiable and intangible benefits to each of the funding sources.

D. The plan should explain how the State will satisfy Federal requirements for competition in procurements under grants.

15520.5 Budget

A. The plan should include a proposed acquisition and operational budget.

B. The plan should provide a schedule of budgeted expenditures that corresponds with the activity schedule and resource statements.

C. The plan should explain how the State proposed to obtain State funds for the equipment, or that matching State funds are available.

D. The plan should include an analysis of the contract life cycle.

15530. EVALUATION FACTORS - SERVICES

15530.1 Service Need

A. The plan should describe the requirement the service is to support, such as:

1. New system for a program(s) not previously supported,
2. Redesigned system for a program(s) currently supported,
3. Growth in programs currently supported,
4. Lack of in-house capability, or
5. One-time activity for which resources are not allocated.

B. Standardized forms, uniform and consistent use of terms, input codes and enforcement, and standardized operation methods should be included for maximum system efficiency.

C. Data codes should be compatible with other programs administered by the State to enable possible future integration of the systems.

D. The plan must provide data exchange, a degree of centralization and enforced uniformity in verification and processing to increase the likelihood of fraud and abuse detection.

E. The system must provide for automated editing and validation of new information against that contained in the system or an interfacing system.

15530.2 Service Objective

The plan should explain what the service is supposed to do and how it will support the programmatic or administrative objectives of Medicaid, e.g:

A. New or improved service delivery,

B. Operational efficiency, and/or

C. Programmatic or administrative accountability.

15530.3 Nature and Scope of the Service

A. The plan must identify the program(s) covered and give sufficient detail to enable each program component to identify functions supported by the service.

B. The plan must describe the relations and interfaces of the service to another system(s).

15530.4 Acquisition Schedule

A. The plan must provide major acquisition milestones and target dates, e.g., preparation of request for proposals (RFP), RFP advertisement, bid evaluation, contract award.

B. The plan should allow time for requisite approvals.

C. The plan should name the State project director with functional title and telephone number.

15530.5 Alternative Considerations

The plan must explain why the proposed service was selected, and the advantages of it, versus other means of satisfying the stated needs and objectives.

15530.6 Cost Analysis/Benefits Anticipated

A. The plan must provide the estimated cost to obtain the service.

B. The plan should give the period of time the State will use the service.

C. The plan must include a methodology for directly charging costs of the service to the various funding sources.

D. The plan must explain the proposed methodology for distributing overhead costs that cannot be directly charged.

E. The plan should explain the benefits of satisfying the requirement through use of the service as opposed to in-house support.

F. The plan should explain the quantifiable and intangible benefits to each of the funding sources.

G. The plan should explain how competitive procurement requirements will be met.

15530.7 Budget

A. The plan must include a proposed budget.

B. The plan should explain how the State proposes to obtain State funds for the service or that matching funds are available.

NOTE: When systems development is not dependent upon the award of an outside equipment contract, the supplemental information in §§ 15540 and 15550 should be included in the initial APD. If any of the information is not initially available, its absence must be explained.

15540. SUPPLEMENTAL EVALUATION FACTORS - SYSTEMS

15540.1 System Need

The report must explain any administrative modifications required, e.g., new or revised internal processes, organizational structures, communications flows, workload distribution, other program adjustments for support.

It must evaluate the management and administrative impact, e.g., on the process flow, structure of the agency, fiscal control, report responsibility.

15540.2 Nature and Scope of the System

A. The report must describe the relationship of the proposed system to another existing system(s), and how the systems will interface.

B. The report must specify the manual functions and the automated functions within the system.

C. It must specify how the new system will exchange data with related existing systems, such as MMIS, SSI, AFDC, IV-D, Buy-In, SDX, BENDEX, EPSDT.

D. It should incorporate batch processing, on-line interactive processing or a combination of both to accommodate presently envisioned or future variations within the State. A comparison between total on-line update versus batch update processing should be made to determine the most cost effective method for the area and system.

E. It must provide training and training resource materials for the users.

15540.3 System Accountability

A. The report must incorporate appropriate administrative, technical and physical safeguards to assure the security and integrity of system hardware, software, records and files.

B. The plan should include a description of backup, restore, and restart capabilities of the system.

15540.4 Cost Analysis/Benefits Anticipated

A. The report must include a detailed calculation showing the cost/benefit ratio.

B. The report should classify the benefits to be derived as to:

1. Quantitative cost reduction,
2. Quantitative cost avoidance, and
3. Quantitative tangible/intangible benefits.

15540.5 Resource Statement

A. The report must provide an estimate of resources required to develop and operate the system, e.g., personnel, hardware, software.

B. The plan should commit State staff resources or describe how the State will acquire needed resources from an outside source(s).

C. The report should indicate that the State has sufficient equipment capacity to develop and operate the system, or describe how the State will acquire the equipment.

D. Evidence of compliance with Federal procurement regulations must be provided.

15540.6 Budget

The proposed budget must be itemized as to design/development/implementation and operation expenses.

15550. SUPPLEMENTAL EVALUATION FACTORS - EQUIPMENT

15550.1 Equipment Utilization

A. The plan should contain statistical information on the historical growth rate trend in equipment utilization and the reason(s) for the growth, if there are reasons other than those described under the section on equipment need.

B. Sufficient terminals and printers should be provided in an automated system to minimize response time without resulting in excess dormant time for the equipment. The plan should justify adequate hardware requisitions.

15550.2 Proposed Configuration

A. The report must describe the type, capacity and configuration of the proposed equipment.

B. The report should describe how the proposed equipment will be integrated with existing equipment.

C. The report should provide for backup for alternative action in the event of system malfunction.

D. A structured, top-down, modular design should be used to provide flexibility and ease of maintenance permitting rapid incorporation of regulatory or other changes in the eligibility criteria.

E. The plan should provide for an integrated data base that can be updated in a timely manner across different programs covered by the system.

15550.3 Alternative Considerations

A. The report should outline the alternatives considered, and their estimated costs and specify why the proposed equipment configuration was chosen.

B. The report should indicate the type and capacity of currently owned hardware.

15550.4 Conversion Considerations

A. The report should indicate that software conversion is a consideration and explain the steps the State has taken to minimize potential conversion problems, such as:

1. If application software is designed to operate on more than one kind of equipment, e.g., ANSI COBOL is primary language,

2. If the data base management system is designed to operate on more than one kind of equipment, and

3. If new or redesigned systems are scheduled so that detailed specifications preparation and system development will follow selection of the new equipment.

B. The planned schedule for delivery of the new equipment and release of old equipment should allow sufficient time for software conversion when necessary.

C. The report must explain the impact on existing operations outside of ADP.

15550.5 Security

A. The plan should provide for inclusion of technical specifications for features to accommodate known security requirements.

B. Privacy Act considerations must govern security.

15550.6 Site Preparation

The plan should explain site preparation plans and costs, or should state that the current site is adequate.

15550.7 Resource Statement

There must be sufficient documentation to support installation and maintenance plans and design principles.

15550.8 Proposed Activity Schedule

A. The report should identify specific tasks, decision points and milestones for each phase of the new equipment acquisition, implementation and operation, e.g.,

1. Planning phase:
    a. Determination of needed capacity,

    b. Coordination of equipment acquisition time frames with those of new or redesigned system development schedules, and

    c. Definition of system specifications.

2. Acquisition phase:
    a. Request for proposal preparation,
    b. Request for proposal advertisement,
    c. Bid evaluation, and
    d. Contract award.

3. Implementation phase:
    a. Site preparation,
    b. Delivery acceptance,
    c. Equipment installation,
    d. Equipment testing,
    e. Conversion of software and files,
    f. Any parallel operation,
    g. Initial assessment of equipment operational efficiency,
    h. Release of old equipment, and
    i. System fine tuning.

4. Operational phase:
    a. Monitoring of equipment utility, capacity and cost, and
    b. Performance measurement.

B. The schedule should allow time for requisite approvals.

C. The schedule should allow time for corrective action in the event of time slippages or cost overruns.

D. The conversion plan must provide a detailed description of the nature and scope of the activities to be undertaken and the methods to be used to accomplish the project.

15550.9 Cost

A. The report must estimate cost for acquiring, including conversion cost, and operating the proposed system configuration.

B. The report should compare the estimated cost of acquiring and operating the new equipment to the cost of the equipment currently in use.

C. The report must include a methodology for directly charging acquisition and operational costs to the various funding sources.

D. The level of needed mechanization must be specified with an estimate of traffic and memory requirements to support the hardware requested.

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MEDICAID ELIGIBILITY DETERMINATION
INFORMATION RETRIEVAL SYSTEM (MEDIRS)

Section Page

CHAPTER VIII

Income and Eligibility Verification System

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15800. BACKGROUND OF INCOME AND ELIGIBILITY VERIFICATION SYSTEM (IEVS)

The Deficit Reduction Act of 1984 (DRA) requires States to have an income and eligibility verification system. Section 2651 of DRA amended the Social Security Act (the Act), the Food Stamp Act, and the Internal Revenue Code to require and enable federally funded State public assistance and unemployment agencies to make more accurate eligibility determinations and benefit payments. State agencies (SAs) are required to exchange information with each other and to obtain and use unearned income data from the Internal Revenue Service (IRS), other income and wage data from the Social Security Administration (SSA), and State Wage and Unemployment Insurance Benefit files. The agencies must assure that appropriate privacy and procedural safeguards are applied in using the information, and that verification is undertaken to protect applicants and recipients from the consequences of erroneous information.

The Omnibus Budget Reconciliation Act of 1986 clarified that States are not required to use all of the information obtained through IEVS to verify the eligibility of Medicaid recipients, and they can target their system to uses which are likely to be most productive and cost-effective. Use of the information means to review and compare the case file against the information received, verify the information (where appropriate), determine whether the information affects eligibility or the amount of medical assistance payment, and enter in the case file that no action is necessary, or notify the Medicaid recipient of an intended adverse action.

Regulations implementing IEVS provisions were effective May 29, 1986 unless States applied for and received approval for a delay not to exceed September 30, 1986.

To assure the confidentiality of tax return information, the provisions require participating SAs to obtain and use IRS unearned income data as prescribed in IRS Publication No. 1075, Tax Information Security Guidelines for Federal, State, and Local Agencies.

15801. REQUESTS FOR INFORMATION AND DATA EXCHANGES

IEVS regulations require you to request information from other agencies to verify Medicaid eligibility and the correct amount of medical assistance payments for applicants and recipients.

A. Participant Programs.--The following State programs are required to participate in the IEVS program:

- o AFDC under title IV-A of the Act
- o Medicaid under title XIX of the Act
- o Unemployment Compensation (UC) under the Internal Revenue Code (State Wage Information Collection Agencies (SWICAs) may gather data for UC.)

- Food Stamp Program under the Food Stamp Act

- Any State program under a plan approved under titles I, X, XIV, or XVI of the Act.

B. Information To Be Requested.--The programs named in A. must request information as follows:

1. State Wage Information.--Maintained by the SWICA during the application period and at least quarterly thereafter.

2. Net Earnings.--From self-employment, wage, and payment of retirement benefits maintained by SSA for the applicants during the application period and for recipients for whom the information has not previously been requested.

3. Benefit Information.--Any other eligibility-related information available from SSA under titles II and XVI of the Act.

4. Unearned Income (e.g., Interest).--Available from IRS during the application period and at least yearly thereafter. IRS only accepts magnetic tape requests from a single coordinating SA (CSA) within the State. Because there is more than one program agency (AFDC, Medicaid, Food Stamp) in the State and Adult Assistance in the territories that is required to obtain IRS information, designate one agency as the CSA. The CSA shall consolidate the requests from the requesting programs within the State, and submit monthly a single tape request to IRS. Advise CSAs to closely follow the procedures in Rev. Pro. 85-21 for requesting and receiving data.

5. Unemployment Compensation Information.--Information maintained by the agency administering State unemployment compensation laws.

- For Medicaid applicants during the application period and at least 3 subsequent months,

- For Medicaid recipients at the time employment is reported lost and at least 3 subsequent months, and

- For Medicaid recipients and applicants receiving UC benefits until reported exhausted.

6. Other Information.--Any additional income, resource, or eligibility information relevant to determining eligibility or correct payment amounts in the State or other States administering any of the programs listed above.

C. Exceptions.--Exceptions to the above requirements may be made when:

- An individual is institutionalized. Obtain and use information from SWICAs only during the application period and on a yearly basis, and from UC agencies only during the application period.

- The Secretary approves a State application to request and use income information source(s) alternative to the data sources listed above.

- The agency administering the AFDC program, or SSA under §1634 of the Act, determines the eligibility of an applicant or recipient.

D. Written Agreements.--Before requesting data from or releasing data to another agency, written agreements between the agencies exchanging data must be in effect. The written agreements at a minimum must specify:

- Information to be exchanged,

- Titles of all agency officials with authority to request income and eligibility information,

- Methods with formats to be used and the timing for requesting and providing the information,

- Safeguards limiting the use and disclosure of information as required by Federal, State law, or regulations,

- The method, if any, the agency uses to reimburse reasonable costs to furnish the information, and

- In an agreement with a SWICA or UC agency and the Medicaid agency, the Medicaid agency must obtain information on applicants at least twice monthly.

15802. USE AND VERIFICATION OF SOCIAL SECURITY NUMBER (SSN)

As a condition of eligibility, SAs must require each individual requesting Medicaid services to furnish his or her SSN. Advise the applicant of the authority under which the SSN is requested and that their SSN will be used to verify income, eligibility, and amount of medical assistance payments under the IEVS program.

If the SSNs are missing from the case record, you must require the individual to furnish them. If an applicant or recipient cannot recall his or her SSN(s), or has not been issued an SSN, you must assist in completing an application for an SSN, and either send the application to SSA, or request SSA to furnish the number if there is evidence that the individual was previously issued an SSN.

However, pending issuance or verification of the individual's SSN(s) by SSA, do not deny or delay services to an otherwise eligible applicant. Also, verify the SSN(s) of each applicant and recipient with SSA to ensure that each SSN furnished was issued to that individual and to determine whether other SSNs were issued.

15805. ALTERNATE SOURCES OF DATA

IEVS regulations allow SAs to apply for approval to use alternative sources of data. The Secretary is authorized by 42 CFR 435.948(e) to approve State applications to request and use income information from a source(s) alternative to those listed in 42 CFR 435.948(a) to verify Medicaid eligibility and correct benefit payments. The authority to approve or disapprove use of alternative data sources was redelegated to HCFA Regional Administrators (RAs) effective July 9, 1986.

A. Application Approval.--To be approved the SA shall submit an application to the HCFA RA demonstrating that the alternative source is as timely, complete, and useful for verifying eligibility and benefit amounts as the required sources.

The application must provide documentation which compares the use of the proposed alternative data source to the required data source. These comparisons must show why the alternative source is as adequate or superior to the required source with respect to:

1. Timeliness.--Available within the same timeframe as the required source or more frequently;

2. Completeness.--Contains the same information or additional information of the same data type; and

3. Usefulness.--Has the potential for resulting in as many or more case actions; e.g., recipient terminations, applicant denials, or fraud referrals, at less cost to the State.

Include an explanation in the application of the methodology used to test the use of the alternative source, with test results. Submit an evaluation of using the alternative source versus the required source at the end of 1 year to the RO.

Partial approval may be received for those aspects of the application (alternate source(s)) which are approvable.

To the extent that applications or portions of applications are not approved you must continue to meet the requirements of 42 CFR 435.948(a).

NOTE: An application proposing the alternate source(s) under one Federal agency's regulation (HCFA) is not automatically considered an application under another Federal agency's regulation (Food and Nutrition Service (FNS) or Family Support Administration (FSA)). The SA must submit a separate application for consideration under another Federal agency's regulation.

B. Application Review.--The HCFA RO reviews the State's application for using an alternate source of income data and consults with its counterparts in the FNS and FSA, and, when necessary, the Department of Labor.

Consultation with counterparts from the Employment and Training Administration (ETA) of the Department of Labor may be necessary when an application for alternate source(s) includes source(s) required or proposed which is under its jurisdiction (i.e., State wage information maintained by the SWICA and unemployment compensation information maintained by the agency administering State unemployment compensation laws). Consultation with counterparts in other Federal agencies is only to advise them of and coordinate the proposed alternate sources for a State under each Federal agency's regulations.

Review of the agency's application for approval is limited to proposed alternate sources and to those sources meeting the requirements for timeliness, completeness, and usefulness. The RA notifies the SA of its determination within 30 days of receipt of an application. Additional information may be requested from the State by the RO, if necessary, and a determination will be made within 30 days of receipt.

15807. SAFEGUARD REQUIREMENTS FOR IRS UNEARNED INCOME DATA

The law requires SAs to exchange information with each other and to obtain and use unearned income data from the IRS, other income and wage data from the SSA, and data from State Wage and Unemployment Insurance Benefit files, and to ensure that appropriate privacy and procedural safeguards are applied in the use of the information. The SA must provide and maintain assurances that the information is used only for the purpose of determining eligibility and the amount of benefits to be granted for the program it is administering. IRS unearned income data are required to be obtained and used as prescribed by the Commissioner of IRS. IRS prescribes its technical and procedural requirements for obtaining and using unearned income data from IRS files in Internal Revenue Procedure 85-21 (Rev. Pro. 85-21). IRS Publication 1075 (IRS Pub. 1075), Tax Information Security Guidelines for Federal, State, and Local Agencies, provides detailed procedures for safeguarding the information and for responding to IRS safeguard recordkeeping and reporting requirements.

IRS safeguard guidelines pertain not only to those agencies which receive Federal tax information directly from IRS, but also to those agencies or agents which receive it from secondary sources such as the SSA and Federal lending agencies. Program agencies receiving IRS information, directly or indirectly, are expected to follow IRS guidelines to prevent unauthorized uses of the information and to protect the confidentiality of that information. Conformance to IRS safeguard requirements detailed in IRS Pub. 1075 meet the safeguard requirements of §6103(p)(4) of the Internal Revenue Code and the Federal regulations described in 42 CFR 431.300ff. pertaining to safeguarding information on applicants and recipients.

A. SA Responsibilities for Safeguarding IRS Data.--In providing the required safeguards that restrict unauthorized use or disclosure of IRS unearned income data, the program agency or a single CSA is responsible for the following:

- Ensuring that appropriate safeguards are employed in the use of the data,
- Providing physical security for the data,
- Coordinating and overseeing the dissemination of the data,
- Monitoring of safeguard activities, and
- Responding to IRS safeguard reporting requirements.

If the CSA approach is not determined to be satisfactory or workable, each program agency (AFDC, Medicaid, Food Stamp, Adult Assistance) may respond individually to IRS safeguard requirements. Note that once an option is taken in dealing with IRS, use the same approach to conform with the IRS safeguard requirements (e.g., coordinated or individual program).

1. Safeguards Employed Using Data

o Use IRS data only for valid administrative needs in verifying the income and eligibility of applicants and recipients. (See §XVII of IRS Pub. 1075.)

o Ensure that IRS data are made available only to personnel authorized to use the data. Restrict access to tax return information to designated personnel. (See §X of IRS Pub. 1075.)

o Provide security procedures and instructions, orientations, and training to all agency employees to ensure their awareness and compliance for using IRS information. (See §VIII of IRS Pub. 1075.)

2. Providing Data Physical Security.--Assure that IRS tax return information is adequately stored and processed so that it is protected against unauthorized disclosure for other purposes. Sections XII, XIII, XIV, XV, and XVII of IRS Pub. 1075 provide detailed instructions on processing controls, providing computer system/storage security, and protection methods.

3. Coordinating/Overseeing Data Dissemination.--Since more than one program agency within the State (AFDC, Medicaid, Food Stamp, Adult Assistance) is required to use IRS information, centralize safeguard responsibility, and establish and maintain uniform IRS safeguard standards.

Coordinate and oversee the dissemination of IRS data throughout your organizational structure and whenever a contractor is used to process Federal return information. Any statistical reports produced by you must not identify a particular individual directly or indirectly. Properly dispose of the IRS tax return information upon completion of its use.

SA shall refer to §§III, VI, XI, XII, and XVIII of IRS Pub. 1075 for detailed requirements and instructions on this subject.

4. State Monitoring of Safeguard Activities.--As a condition for receiving IRS unearned income data, assure a safeguard program that meets the specifications, procedures, and conditions of IRS safeguard requirements is in place. (See guidelines in IRS Pub. 1075.) Take corrective action where specific weaknesses in safeguard initiatives are identified by you, Federal oversight agencies, or IRS.

You are responsible for monitoring the safeguards, including onsite inspections of the local agencies which received return information from you. (See §V of IRS Pub. 1075.)

Conduct internal inspections (see §IV of IRS Pub 1075) to ensure the safeguard programs are in compliance with IRS requirements and to validate the information provided in the Safeguard Procedure and Safeguard Activity Reports.

5. Safeguard Activity Report.--An annual safeguard activity report shall be submitted to the ROs of the Federal agencies which have oversight responsibility. This report shall update the initial safeguard procedure report (details the security of and individuals responsible for requesting and accessing IRS information, the flow of the information through the SA, and information describing the need for, use of, and disposal of IRS data) to ensure that current and reliable information is provided on the programs' safeguard activities.

Section VII of IRS Pub. 1075 provides the information requirements for this report. Attached is a recommended IRS approved format for your use to maintain uniformity and ease of submittal. (See Exhibit 1 of this chapter.) Annual Safeguard Activity Reports shall be submitted by September 30 of each year.

Annual activity reports are reviewed and analyzed by Federal oversight agencies (e.g., HCFA, FSA, FNS), and the results are used for monitoring ongoing safeguard activities. Problems or concerns regarding the reports will be discussed with SAs, as necessary, prior to reporting to IRS on the operation of safeguard procedures under IEVS.

B. Federal Monitoring Responsibilities.--Federal agencies responsible for State program oversight are charged with ensuring that you comply with IRS-specific requirements for safeguarding the unearned income data disclosed by IRS. Safeguard monitoring responsibilities for HCFA have been delegated to HCFA ROs. These responsibilities include:

o Monitoring the ongoing safeguard activities employed by SAs by reviewing and analyzing safeguard activity reports,

o Providing IRS with monitoring and audit reports on current State practices, and

o Conducting onsite reviews of each SA's safeguards at least once every 5 years.

C. IRS Audits of Federal/State Safeguard Activities.--IRS has the authority to conduct its own safeguard reviews at the Federal, State, and local levels either:

o When the IRS believes unearned income information is not being properly safeguarded or protected, or

o To insure Federal oversight agencies are properly monitoring safeguards employed by State programs which requested unearned income information.

You are encouraged to seek further guidance, if necessary, from the ROs of Federal agencies maintaining oversight. Questions concerning IRS requirements may be directed through Federal agency channels or directly to IRS district offices.

Exhibit 1

SAFEGUARD ACTIVITY REPORT

STATE ________________

A. Reporting/Participating Programs (Circle one or all. A report must be submitted for all programs, either as one comprehensive report or separate reports for each program.)

1. Aid to Families with Dependent Children program under part A of title IV of the Social Security Act.

2. Medicaid program under title XIX of the Social Security Act.

3. Food Stamp program under the Food Stamp Act of 1977.

4. For the territories: Any Adult Assistance program under a plan approved under title I, X, XIV, or XVI of the Social Security Act.

B. Required Report Information (Refer to section VII of IRS Pub. 1075.)

1. Describe in detail significant changes in safeguard procedures or authorized access to IRS unearned income information since the time the safeguard procedures report was submitted. Describe any changes or enhancements to physical and computer security measures.

2. Describe internal inspection initiatives and results. (See item VII.2 of IRS Pub. 1075.)

3. Describe the disposal process of the IRS unearned income information. Identify the material destroyed during the year and the date and manner of destruction.

4. Describe any information disclosures which have taken place since the Safeguard Procedure Report was submitted. (Include the recipients.)

5. Are the statements and safeguard procedures described in your initial Safeguard Procedure Report submitted on ________ still in effect?
YES ________ NO ________
Describe any differences/changes in that report that you have not discussed in items 1-4.

C. This Safeguard Activity Report serves as the Agency's certification that it is protecting return information in accordance with IRC 6103(p)(4).

____
Signature and Title of Certifying Official

____
Date

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